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**Alcohol consumption behaviour of young people in Thailand:  
Perspectives of stakeholders in Petchaburi Province**

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**Doctor of Philosophy**

**The University of Edinburgh**

**2015**

## **Abstract**

This thesis examines the issue of young people and alcohol consumption in order to understand their behaviour and experiences in Thailand. Alcohol consumption is socially accepted as a pleasurable activity in many countries world-wide. Alcohol consumption among young people in Thailand has been affected by the spread of western culture, which has encouraged an acceptance of drinking alcohol as being fashionable and as a means of promoting social relationships. This study aimed to gain detailed knowledge of the alcohol consumption behaviour of secondary school students in Petchaburi Province, Thailand, using a survey and participatory action research to understand the perspectives of a variety of stakeholders in one community towards young people's behaviour and alcohol consumption.

Both quantitative and qualitative methods were adopted in order to explore and interpret students' and stakeholders' perspectives. The survey was the first phase of the research and used a questionnaire to identify the characteristics and problems of the alcohol consumption behaviour of 845 secondary school students aged 15-19 sampled from one school in each of the eight districts of Petchaburi Province. Logistic regression was used to select one school for conducting Participatory Action Research (PAR) in one community "C" in phase two of the research. An ecological approach was applied for capturing a variety of perspectives, at the intrapersonal, interpersonal, institutional, community, and public policy level using focus groups and in-depth interviews with eight students, eight parents, three health professionals, two teachers, one community leader, one policeman and one Buddhist monk.

The study findings demonstrated that alcohol consumption among young people was common. The data showed that 45.9% of participants had had an alcoholic drink in the previous thirty days. Students usually drank on Fridays and Saturdays with their gangs. All or almost all of their close friends were reported as having an alcoholic drink. Most students were affected by peer pressure, some students copied their family members' drinking behaviour, and some of them were influenced by fashion, community culture and advertising. Moreover, students who drank alcohol demonstrated the negative consequences of drinking.

Drinking at an early age was defined by all stakeholders in the selected Community C as unpleasant and intolerable behaviour. Students started to develop strategies in order to access alcohol. Moreover, alcohol was readily available due to the lack of restrictions being enforced in community shops by government policy, alongside inconsistent enforcement of the Alcohol Act.

The development of prevention strategies was recommended for action at all levels. This includes within families, in schools, and within affected communities through the introduction of policies such as the restriction of alcohol sales and advertising, and by raising awareness among young people and their communities. Finally, Buddhist practices were discussed as a key element in the development of an intervention programme to reduce the problematic drinking behaviour of young people.

# Contents

<b>Preface</b> .....	i
<b>Abstract</b> .....	ii
<b>Contents</b> .....	iii
<b>Acknowledgements</b> .....	xii
<b>Declaration</b> .....	xiv
<b>Chapter 1: Introduction</b> .....	1
1.1 Introduction .....	1
1.2 Background .....	1
1.2.1 Global trends in young people's alcohol use .....	1
1.2.2 Young people and alcohol consumption in England and Scotland .....	4
1.3 Alcohol consumption by young people in Thailand .....	6
1.4 Thai culture and alcohol consumption .....	8
1.5 Buddhism in Thailand .....	10
1.6 The context of the study .....	11
1.7 Research aim and questions .....	13
1.8 The structure of the thesis .....	14
<b>Chapter 2: Young people and alcohol consumption</b> .....	18
2.1 Introduction .....	18
2.2 Search parameters .....	18
2.2.1 Key search words .....	19
2.3 Global alcohol consumption among young people .....	19
2.3.1 Drinking prevalence and patterns .....	20
2.4 Alcohol consumption by young people in Britain .....	23
2.5 Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) .....	29
2.6 Alcohol consumption among young people in Thailand .....	31
2.6.1 Alcohol history in Thailand .....	31
2.6.2 Alcohol use in Thailand .....	32
2.6.3 Drinking patterns of young people in Thailand .....	32
2.7 Consequences of alcohol consumption for young people .....	34
2.7.1 Consequences of drinking among young people in the UK .....	35
2.7.2 Consequences of drinking among young people in Thailand .....	36
2.8 The Location for young people to drink and drinking motives .....	38
2.8.1 Location of drinking .....	38
2.8.2 Drinking motives .....	39
2.9 Factors influencing young people's alcohol consumption behaviour .....	41
2.9.1 Family roles and young people's drinking .....	42
2.9.2 Peer pressure .....	44
2.9.3 School context .....	46
2.9.4 Media and advertisement .....	47
2.10 Prevention strategies to reduce alcohol consumption by young people .....	48
2.10.1 Prevention strategies at Policy Level .....	49
2.10.2 Prevention strategies at Family Level .....	50
2.10.3 Prevention strategies at School Level .....	51
2.10.4 Prevention strategies at Community Level .....	52
2.10.5 Prevention strategy using peers .....	53
2.11 Buddhism and alcohol consumption .....	54

2.11.1 The history of Buddhism and Buddhism in Thailand.....	54
2.11.2 Culture and alcohol use.....	55
2.11.3 Religion and young people's alcohol use.....	62
2.12 Alcohol policy.....	65
2.13 Strength and limitation of the studies.....	67
2.14 Conclusion.....	68
<b>Chapter 3: Theoretical Framework.....</b>	<b>71</b>
3.1 Introduction.....	71
3.2 Child Development.....	72
3.2.1 Definition of adolescence (young people).....	72
3.2.2 Developmental changes during adolescence.....	74
3.2.2.1 The Psychoanalytical Theory.....	77
3.2.2.2 Social Learning Theory.....	80
3.2.2.3 Cognitive Development Theory.....	81
3.3 Ecological Approach.....	83
3.4 The Ecological Approach.....	84
3.4.1 Bronfenbrenner's Ecological Model.....	84
3.4.2 The Ecological Approach in my study.....	86
3.4.2.1 Intrapersonal Level.....	88
3.4.2.2 Interpersonal Level.....	89
3.4.2.3 Institutional Level.....	90
3.4.2.4 Community Level.....	91
3.4.2.5 Policy Level.....	92
3.5 Action Research as a whole picture of my research.....	94
3.5.1 The origin of Action Research.....	95
3.5.2 The process of Action Research.....	96
3.5.3 Participatory Action Research.....	98
3.5.4 Participatory Action Research process.....	99
3.6 The methods used for data collection.....	100
3.6.1 Focus group.....	100
3.6.2 In-depth interview.....	103
3.7 Conclusion.....	105
<b>Chapter 4: Phase One – The Survey.....</b>	<b>107</b>
4.1 Introduction.....	107
4.2 Study sites of the survey study.....	107
4.3 Participants.....	109
4.4 Tool development and application.....	115
4.5 Validity and reliability.....	123
4.5.1 Content validity.....	123
4.5.2 Pilot study.....	124
4.6 Data collection.....	125
4.6.1 The data collection process.....	125
4.6.2 Research assistants' training.....	128
4.6.3 Bias reduction.....	129
4.7 Data analysis.....	130
4.8 Ethical considerations.....	132
4.8.1 Anonymity.....	132
4.8.2 Voluntary participation.....	133
4.8.3 Informed consent.....	133
4.9 Conclusion.....	134

<b>Chapter 5: Findings: Survey study</b>	136
5.1 Introduction	136
<b>Part One: Findings of the survey study</b>	136
5.2 Response rates	136
5.3 Demographic data and family members' drinking	137
5.3.1 Age of students	137
5.3.2 Religion	138
5.3.3 Students' Grade Point Average (GPA)	139
5.3.4 Students' monthly expenditure	140
5.3.5 Students' families' monthly income	141
5.3.6 Family member relationships	142
5.3.7 Students' living arrangements	143
5.3.8 What do students want to do after leaving school?	144
5.3.9 Family members who have drunk alcohol	145
5.3.10 Family members' drinking behaviour	147
5.4 Questions about how often you drink	149
5.4.1 Self-reported alcohol consumption	149
5.4.2 Usual frequency of drinking	150
5.4.3 Days on which students drank alcohol	151
5.5 Questions about what you drink	152
5.5.1 Types of alcohol which students consumed during the previous 30 days	152
5.5.2 The unit of alcoholic drink which students consumed during the previous 30 days	153
5.6 Questions about the effects of drinking	155
5.6.1 Students who have been drunk	155
5.6.2 Students who deliberately tried to get drunk	156
5.6.3 Students who have got 'really drunk'	156
5.6.4 Frequency of having five or more alcoholic drinks on the same occasion	157
5.6.5 Consequences of drinking alcohol	158
5.7 Questions about where you drink and with whom	160
5.7.1 Location of students' drinking	160
5.7.2 Who did students drink alcohol with?	161
5.7.3 Number of close friends who had drunk alcohol	161
5.8 Questions about buying alcohol	162
5.8.1 Sources of buying alcohol	162
5.8.2 Students who attempted to buy alcohol from a shop, supermarket or non-licence shop	163
5.8.3 Students who attempted to buy alcohol from a pub, bar or club	164
5.8.4 Students who obtained alcohol from someone else	165
5.8.5 Money which students spent on alcohol	166
5.9 Questions about drinking and your family attitude	167
5.9.1 Family feeling to students' drinking	167
5.9.2 Family thinking towards students' drinking	168
5.9.3 Parents allowing students to drink at home	168
5.10 Questions about why you drink	169
5.10.1 Causes of drinking	169
<b>Part Two: The association analysis of variables</b>	172
5.11 The exploration of the association between different variables of students who had consumed alcohol	172

5.11.1 The association between demographic information and students' alcohol consumption behaviour.....	172
5.11.2 The association between data relating to family members' drinking and students' alcohol consumption behaviour.....	175
5.11.3 The exploration of the association between demographic information and the frequency of students' alcohol consumption.....	176
5.11.4 The exploration of the association between family members' drinking behaviour and the frequency of students' alcohol consumption.....	179
5.11.5 The exploration of the association between students' purchasing alcohol behaviour and the frequency of students' alcohol consumption.....	180
5.11.6 The exploration of the association between family attitudes and frequency of students' alcohol consumption.....	182
5.11.7 The association between the family members' drinking, students' friends' drinking, sources of purchasing alcohol and the frequency of students who have five or more drinks on the same occasion.....	184
5.11.8 The association between students' demographic data and the purchasing alcohol behaviour.....	186
5.11.9 The association between the frequency with which students got drunk and the purchasing alcohol behaviour.....	189
5.11.10 The association between students' demographic data and the frequency with which students got drunk.....	190
5.11.11 The association between the number of friends that participants have who have consumed alcohol and the frequency of getting drunk.....	192
5.12 Summary.....	193
<b>Part Three: The logistic regression analysis.....</b>	<b>194</b>
5.13 Method for Selecting a School for Participatory Action Research.....	194
5.13.1 The variables included in the model.....	194
5.13.2 Factors associated with drinking alcohol during the previous month.....	195
5.13.3 Selecting a school for Participatory Action Research.....	197
5.14 Conclusion.....	199
<b>Chapter 6: Phase Two: Qualitative research design for Participatory Action Research.....</b>	<b>202</b>
6.1 Introduction.....	202
6.2 Study site for Participatory Action Research.....	202
6.3 Participatory Action Research (PAR) .....	203
6.4 The participants: recruitment and access.....	205
6.4.1 Secondary school students (High school students) .....	206
6.4.2 Parents or guardians.....	207
6.4.3 Advisory teachers.....	209
6.4.4 Healthcare providers.....	210
6.4.5 A community leader.....	211
6.4.6 A policeman.....	211
6.4.7 A Buddhist monk.....	211
6.5 Data collection.....	212
6.5.1 Focus groups.....	212
6.5.2 In-depth interviews in my study.....	214
6.5.3 Scheduled questions for qualitative data collection.....	215
6.6 Data collection process.....	216
6.6.1 Focus groups.....	216
6.6.1.1 Secondary school students.....	216
6.6.1.2 Parents or guardians.....	217

6.6.1.3 Healthcare providers.....	218
6.6.2 In-depth interviews.....	219
6.6.2.1 Advisory teachers.....	220
6.6.2.2 A Community leader.....	220
6.6.2.3 A Policeman.....	221
6.6.2.4 A Buddhist monk.....	221
6.7 Data analysis.....	222
6.8 NVivo 9.....	223
6.9 Ethical consideration.....	227
6.10 Validity of the study.....	228
6.11 Conclusion.....	229
<b>Chapter 7: Participatory Action Research - Findings.....</b>	<b>230</b>
7.1 Introduction.....	230
7.2 The perspectives of the stakeholders toward alcohol consumption by young people in Thailand.....	230
7.3 Young people and access to alcohol.....	231
7.3.1 Age of starting drinking.....	231
7.3.2 Parent's views on young people drinking.....	233
7.3.3 Methods used by young people to drink alcohol.....	234
7.3.3.1 Method used for general drinking.....	234
7.3.3.2 Method used to drink alcohol at the school.....	234
7.3.3.3 Methods used to get into pubs/bars to drink alcohol.....	235
7.3.4 What is the favourite alcohol for young people? .....	236
7.3.4.1 Beer.....	236
7.3.4.2 BLEND 285.....	236
7.3.4.3 Lao Pan.....	236
7.3.4.4 Kra Chae.....	237
7.3.5 Where do young people drink alcohol? .....	237
7.3.6 Who do young people drink with? .....	238
7.3.6.1 Drinking with friends at school.....	238
7.3.6.2 Drinking with friends who left school early.....	239
7.3.7 Preferred time when young people enjoy drinking.....	239
7.3.8 Reflection summary.....	240
7.4 Why do the young people drink? .....	240
7.4.1 Family effect.....	241
7.4.1.1 Family members' drinking.....	241
7.4.1.2 Changes in family structure and life style.....	242
7.4.2 Peer effect.....	245
7.4.2.1 Peers in school.....	245
7.4.2.2 Peers who left school early.....	246
7.4.3 School effect.....	247
7.4.4 Community effect.....	248
7.4.4.1 Young people drinking as an effect of adults' drinking.....	248
7.4.4.2 Young people buying alcohol from community shops.....	248
7.4.5 Policy effect.....	250
7.4.6 Advertising.....	251
7.4.7 Loss of self-control.....	252
7.4.8 Culture.....	253
7.4.8.1 The community culture.....	253
7.4.8.2 New generation belief.....	254
7.4.9 Reflection summary.....	255
7.5 Undesirable consequences from drinking alcohol by young people.....	256



7.5.1 Accidents.....	256
7.5.2 Changes in individual behaviour.....	257
7.5.3 Fighting.....	259
7.5.4 Poor school performance.....	259
7.5.5 Health problems.....	260
7.5.6 Reflection summary.....	261
7.6 Prevention strategies.....	262
7.6.1 Prevention strategy by the family.....	262
7.6.1.1 Nurturing care and protection of children at home by the family members.....	262
7.6.1.2 Teaching at home.....	263
7.6.1.3 Parents as a good example.....	264
7.6.2 Prevention strategy by the schools.....	266
7.6.2.1 Modifying the curriculum and teaching at schools.....	266
7.6.2.2 Teachers are a good example.....	268
7.6.2.3 Cutting marks and keeping a ‘Drunk List Record’.....	268
7.6.3 Prevention strategy by the community.....	269
7.6.3.1 Taking care and teaching children in the community.....	269
7.6.3.2 Adults are a good example.....	270
7.6.3.3 Conducting a youth club and providing part time jobs.....	270
7.6.3.4 Constructing sufficient sport fields.....	271
7.6.4 Prevention strategy through policy.....	272
7.6.4.1 Restricting policy enforcement.....	272
7.6.4.2 Continuously setting an anti-alcohol campaign.....	272
7.6.4.3 Noticing of the punishment of people who breaking the Alcohol Act.....	273
7.6.5 Prevention strategy by the healthcare team.....	273
7.6.5.1 Conducting health promotion in schools.....	274
7.6.5.2 Health teaching in hospitals.....	274
7.6.6 Prevention strategy by restricting alcohol sales.....	275
7.6.7 Prevention strategy by increasing young people’s self-awareness.....	276
7.6.7.1 Decision-making and negotiation skills.....	276
7.6.8 Prevention strategy using restriction of alcohol advertising.....	277
7.6.9 Reflection summary.....	278
7.7 How to succeed with the alcohol prevention strategies.....	278
7.7.1 The community network.....	278
7.7.2 Police responsibilities.....	280
7.7.3 Punishment.....	280
7.7.4 Reflection summary.....	282
7.8 Buddhist practice.....	282
7.8.1 Buddhist practice in the Buddhism.....	282
7.8.2 Buddhist practice in the family.....	285
7.8.2.1 Teaching and practice at home.....	285
7.8.2.2 Family members as role models.....	286
7.8.3 Buddhist practice in school.....	287
7.8.3.1 Teaching at the school.....	287
7.8.3.2 Buddhist activities in the school.....	288
7.8.4 Buddhist Practice in the Temple.....	288
7.8.4.1 Teaching at the Temple.....	288
7.8.4.2 <i>Dharma</i> talks.....	289
7.8.4.3 <i>Tamboon</i> .....	289
7.8.4.4 <i>Dharma</i> camp.....	290
7.8.4.5 Ordination.....	290

7.8.4.6 Observing the Five Precepts.....	291
7.8.5 Reflection summary.....	293
7.9 Conclusion.....	294
<b>Chapter 8: Discussion.....</b>	<b>296</b>
8.1 Introduction.....	296
8.2 Alcohol consumption behaviour of young people: Intrapersonal level.....	296
8.3 Alcohol consumption behaviour of young people: Interpersonal level.....	300
8.4 Alcohol consumption behaviour of young people: Institutional (organizational) level .....	310
8.5 Alcohol consumption behaviour of young people: Community level.....	312
8.6 Alcohol consumption behaviour of young people: Policy level.....	317
8.7 Conclusions.....	321
<b>Chapter 9: Conclusion and Recommendations.....</b>	<b>324</b>
9.1 Introduction.....	324
9.2 Research Question 1.....	324
9.3 Research Question 2.....	326
9.4 Contribution to knowledge.....	329
9.4.1 Dimension One: Family.....	331
9.4.2 Dimension Two: School.....	331
9.4.3 Dimension Three: Temple.....	332
9.4.4 Dimension Four: Community and culture.....	332
9.4.5 Dimension Five: Policy.....	333
9.4.6 Dimension Six: Technology and media.....	333
9.5 Implications and Recommendations.....	334
9.5.1 Implications of my findings for the intervention programme.....	334
9.5.2 The proposed intervention programme.....	334
9.5.3 Implications for research.....	336
9.5.3.1 Further research with the wider student population in Petchaburi Province and other regions in Thailand.....	336
9.5.3.2 Further multi-dimensional research.....	336
9.5.4 Implications for education.....	337
9.5.5 Implications for policy.....	338
9.6 Limitation of my study.....	338
9.7 Conclusion.....	339
<b>References.....</b>	<b>341</b>
<b>Appendices.....</b>	<b>371</b>
Appendix A: The questionnaire for survey study.....	371
Appendix B: The research Ethics Approval by The School of Health in Social Science, The University of Edinburgh.....	383
Appendix C: The research Ethics Approval by The Secondary Education Service Area Office 10, Thailand.....	384
Appendix D: Information sheet and informed consent form.....	385
Appendix E: Table of logistic regression analysis.....	395
Appendix F: The focus group and in-depth interview guide.....	409
<b>Figures</b>	
Figure 1.1 Map of districts in Petchaburi Province.....	12
Figure 1.2 Diagram of the process of doing research with nine chapters.....	17
Figure 2.1 Per capita consumption alcoholic beverages.....	20

Figure 2.2 Prevalence of heavy episodic drinking of males in 2004.....	21
Figure 2.3 Prevalence of heavy episodic drinking of females in 2004.....	22
Figure 2.4 Prevalence of heavy drinking among current drinkers (15+ years), 2010.....	22
Figure 3.1 Action Research Model.....	97
Figure 4.1 Map of Petchaburi Province.....	107
Figure 4.2 Map of district locations for the survey.....	108
Figure 4.3 The process of multi-stage sampling for selecting participants.....	111
Figure 4.4 The environment of data collection process.....	126
Figure 4.5 Power point presentation: ‘Type of Alcohol’.....	127
Figure 4.6 The position of the researcher and research assistants.....	128
Figure 5.1 The response rates.....	137
Figure 5.2 Age of respondents.....	138
Figure 5.3 Religion of respondents.....	138
Figure 5.4 Grade Point Average of the respondents.....	139
Figure 5.5 Students’ monthly expenditure.....	140
Figure 5.6 Students’ families’ income.....	141
Figure 5.7 Family member relationships.....	142
Figure 5.8 Students’ living arrangements.....	143
Figure 5.9 Things to do after students leave school.....	144
Figure 5.10 Family members who have drunk alcohol.....	146
Figure 5.11 Family members’ drinking behaviour.....	147
Figure 5.12 The frequency of family members who have been drunk.....	148
Figure 5.13 Proportion of students who consume alcohol.....	149
Figure 5.14 The frequency of drinking.....	151
Figure 5.15 Days of students’ drinking.....	151
Figure 5.16 Types of alcohol.....	152
Figure 5.17 Unit of alcohol drink that students consumed.....	154
Figure 5.18 Students who have been drunk.....	155
Figure 5.19 Students who deliberately tried to get drunk.....	156
Figure 5.20 Students who have been really drunk.....	157
Figure 5.21 The frequency of having five or more alcoholic drinks on the same occasion.....	157
Figure 5.22 Consequences of drinking alcohol.....	159
Figure 5.23 Location of students’ drinking.....	160
Figure 5.24 People who students drink alcohol with.....	161
Figure 5.25 Number of close friends who had drunk alcohol.....	162
Figure 5.26 Source of purchasing alcohol.....	163
Figure 5.27 Students who attempted to buy alcohol from a shop, supermarket or non-licence shop.....	164
Figure 5.28 Students who attempted to buy alcohol from a pub, bar or club.....	165
Figure 5.29 Students who have got alcohol from someone else.....	166
Figure 5.30 Money which students spent on alcohol.....	166
Figure 5.31 Family feeling to students’ drinking.....	167
Figure 5.32 Family thinking to students’ drinking.....	168
Figure 5.33 Parents allowing students to drink at home.....	169
Figure 5.34 Causes of drinking.....	170
Figure 5.35 Causes of drinking by students who got drunk.....	171
Figure 6.1 The study site.....	202
Figure 6.2 The number of students in each school year level of School C.....	203
Figure 6.3 The research framework.....	205
Figure 6.4 The recruitment process of students for the focus group.....	207
Figure 6.5 The recruitment process of parents or guardians for focus group.....	209
Figure 6.6 Coding process.....	223

Figure 6.7 Coding from transcripts by using NVivo 9.....	224
Figure 6.8 The whole picture of research findings of Alcohol consumption behaviour of young people in Petchaburi Province.....	226
Figure 6.9 Main themes - Alcohol consumption behaviour of young people.....	227
Figure 9.1 Model to show factors associated with young people's alcohol consumption behaviour .....	329

## Tables

Table 1.1 Young people's alcohol consumption situation in Thailand.....	7
Table 2.1 The Five Precepts.....	63
Table 3.1 The application of an Ecological Approach to my study.....	93
Table 4.1 The sample size of each school.....	112
Table 4.2 The participant recruitment from eight districts.....	114
Table 5.1 Conversion factors for each type of alcoholic drinks into units of alcohol.....	153
Table 5.2 The association between demographic information and students' alcohol consumption behaviour.....	173
Table 5.3 The association between data relating to family members' drinking and students' alcohol consumption behaviour.....	175
Table 5.4 The association between demographic information and the frequency of students' alcohol consumption.....	177
Table 5.5 The association between family members' drinking behaviour and the frequency of students' alcohol consumption.....	180
Table 5.6 The association between students' purchasing alcohol behaviour and the frequency of students' alcohol consumption.....	181
Table 5.7 The association between family attitudes and frequency of students' alcohol consumption.....	183
Table 5.8 The association between the family members' drinking, students' friends' drinking, sources of purchasing alcohol and the frequency of students who have five or more drinks on the same occasion.....	184
Table 5.9 The association between students' demographic data and the purchasing alcohol behaviour.....	187
Table 5.10 The association between the frequency with which students got drunk and the purchasing alcohol behaviour.....	190
Table 5.11 The association between students' demographic data and the frequency with which students got drunk.....	191
Table 5.12 The association between the number of friends that participants had who have consumed alcohol and the frequency of getting drunk.....	193
Table 5.13 Estimated odds ratios for having drunk alcohol during the previous 30 days..	195
Table 5.14 The predictive equation of predictors of each school.....	198

## Acknowledgements

I am very grateful to many people for their support during this research. First and foremost I would like to thank the students from eight districts in Petchaburi Province and all stakeholders in School C and Community C (students, parents, advisory teachers, healthcare providers, a community leader, a policeman, and a Buddhist monk) who participated in this study, for sharing their experiences. The richness of their accounts allowed me to develop the thesis in a way that contributes to knowledge and understanding of young people and alcohol consumption.

I would like to thank my supervisors, Professor Pam Smith and Dr. Rosie Stenhouse for their support, guidance and encouragement throughout the study and particularly for their critical comments on earlier drafts. I have enjoyed the challenging, stimulating and friendly discussions.

Thanks also to Dr. Anne Robertson who encouraged me to design the research in the first year of my study, to Professor Dr. Graeme Smith for his support with the study enrollment, to Professor Mick Power for his help in modifying the questionnaire, to Dr. Kanchana Junthai, Dr. Montatip Chaivasak, Mrs. Prapaipis Singhasem, Miss Kornasasi Chitdee, Miss Varunee Ket-In, Dr. Pornruedee Nitirat and Mr. Yosapon Leangsomnana for their help in editing the language of the questionnaire and the interview/focus group schedule question in the Thai language. A special thank you goes to Dr. Jennifer M Speirs who proofread my thesis.

I would like to thank the management of the director of Petchaburi Secondary Education Service Area Office 10 and all school principals of eight schools for providing access to the secondary schools in eight districts in Petchaburi Province for the study.

I am grateful to the Royal Thai government and the Office of Education Affairs, the Royal Thai Embassy, London for financial support and problem solving while I lived in the UK and to the Praboromarajchanok Institute for Health Workforce Development for considering me for a scholarship to study abroad.

My thanks also go to friends: Miss Busarin Eiu-Seeyok, Miss Supawan Pimpayorn, Dr. Maturada Muangman, Mr. Kulabutr Komenkul, Mr. Phunpiti Bhovichitra, Mr. Kantitub Tubsuwan, Mr. Chris and Mrs. Niramol Cox, Mr. Keith, Mrs. Virin and Luke Groat, Mr. William and Mrs. Kanchana Parkinson, Mr. Wichai Rodpradith, Mrs. Siriporn Crichton, Mrs. Tunyapat Boontongchinnased, Mrs. Boonsuda Punyasang, Mrs. Sa Hamilton, Miss Pantawanee Suratchadapiwat, Mr. Graham Matthew Kerr, Mr. Martin McGee and Mrs. Varee Craib, Mrs. Jiraporn Boontha, Mr. Kyle and Mrs. Pathamawadee McKay, Mrs. Orathai Raweewong, Mrs. Busarin Suparee, Mrs. Rugee Suayngam and to colleagues who provided words of encouragement and useful comments and discussion on my work, and encouraged and motivated me when I was suffering from health problems and weary from thesis writing. A special thank you goes to Dr. Ashleigh Cairns (GP) at the Gilmore Medical Practice and doctors and clinical staffs at the Royal Infirmary of Edinburgh, Little France who looked after my health problems and gave me effective treatment.

A big thank you to Prakru Siridhammapradipa (Abbot of Thai Buddhist Temple in Scotland), Pra Maha Sombut Pramual, Pra Maha Presert Prommala, Prakru Sungkarak (Wisunupong Sirivaddhano) and the Thai community (Mr. Yongyut Suayngam) who gave me a residence when I arrived in Edinburgh during the first month, and supported me when I was in a confused state.

Finally but most importantly, I thank my family, my older brother (Mr. Manoon Glomjai) and particularly my mother for their endless support and encouragement. Even though my mother stays in heaven, she is always my inspiration for studying for a PhD. I am indebted to them and wish to express my gratitude, appreciation and love.

## **Declaration**

I hereby declare that this thesis and the research on which it reports are my own work.

(Thanee Glomjai)

# Chapter 1

## Introduction

### 1.1 Introduction

This thesis presents a study of the behaviour and experiences of alcohol consumption of young people in Thailand. Due to the advancement of technology and globalisation, alcohol is accessed at a younger age than before. I am a nurse lecturer in Petchaburi Province and work in the community where I face the problem of young people's alcohol consumption every day. I am concerned about this problem and would like to develop appropriate strategies to respond to it by participating with stakeholders in the community. I decided therefore that I needed to undertake research in order to obtain in-depth details of the problem and directly address the gap in the evidence base to understand young people's alcohol consumption and associated behaviour in order to develop appropriate prevention strategies. The research for the thesis has been designed in two phases. Phase One is a survey which aimed to explore the problem in detail in eight schools. Phase Two used Participatory Action Research with key stakeholders in a selected community. The research design and the findings will be presented in detail in the following chapters. In this chapter, I provide the background to the study and present the research aims, the research questions, as well as the context and the structure of the study.

### 1.2 Background

#### 1.2.1 Global trends in young people's alcohol use

Alcohol consumption is prevalent and socially accepted as a pleasurable activity in many countries around the world (Young *et al.*, 2006). This resonates with the United Nations' statement:

*Beverage alcohol is the substance most widely consumed by young people worldwide. Alcohol use is interwoven into many cultures*



*and, in some, the first drinking experience occurs in the context of family events. (United Nations, 2004 p.153)*

However, Young *et al.* (2006) showed that young people's drinking is widely recognized as a leading policy concern and public health problem in many countries throughout the world, and as a cause of accidental death among young people. Moreover, high-volume alcohol consumption is often the cause of injury and personal negative consequences, such as academic failure, unwanted pregnancy, sexually transmitted diseases, property damage, and criminal involvement (Hingson *et al.*, 2005). A report from the World Health Organization (WHO) considers alcohol consumption to be the world's third highest risk factor for disease and disability (WHO, 2011).

The WHO (2014) report identified increasing alcohol consumption by young people (aged 13-15). The report also identified an increasing trend for drinking among 18-25 year olds (WHO, 2011; 2012) and showed the percentage of students (aged 13-15) who had drunk at least one alcoholic drink in the past 30 days. It was found that in the African region, the highest percentage of students who drank alcohol was in the Seychelles (62.1% of boys and 61.2% of girls) and Zambia came second (38.7% of boys and 45.1% of girls). Women in Sub-Saharan Africa are also considered to be at high risk regarding alcohol consumption especially in relation to HIV transmission and poverty. The main cause for alcohol consumption among women in the Zambia is considered to be associated with the economic status and other African countries. Poverty has a significant role in the proliferation of prostitution; young women are vulnerable because of these economic factors and tend to consume alcohol as part of their prostitution activities (Singh *et al.*, 2011). In the Americas, Uruguay was reported to have the highest proportion (62.0% of boys and 57.7% of girls), followed by Saint Lucia (59.2% of boys and 52.2% of girls) and then Argentina (55.4% of boys and 49.0% of girls) (WHO, 2011).

These findings describe the global context of my study, against which I can interpret the alcohol consumption rates in Thailand and understand the extent of the problem for young people there. Within Thailand, young people's alcohol consumption is largely hidden and the main policy focus is on drug misuse. The global figures

presented in the WHO reports helps to highlight the need to focus on young people's alcohol consumption in Thailand.

With regard to the consequences, globally, drinking alcohol is the leading factor for male deaths in the 15-29 year old age group, particularly in Europe, which had a higher risk in all age groups (WHO, 2011). The main causes of deaths were injuries, violence, conflict, and heart disease in this age group (WHO, 2011). Globally, in 2012 about 3.3 million deaths were caused by alcohol consumption. According to the report, most deaths were from cardiovascular diseases, followed by injuries, gastrointestinal diseases (mainly liver cirrhosis) and cancers (WHO, 2014). Similar to the patterns of alcohol consumption, the greatest proportion of related alcohol-attributable deaths is in the European Region, and the lowest are in the African and Eastern Mediterranean Regions (WHO, 2014).

The WHO stated that the world's highest alcohol consumption level is found in the developing world (WHO, 2011). This is particularly so in the South-East Asian Region (SEAR) and in the Western Pacific Region (WPR). Alcohol consumption among male students aged 13-15 in Thailand was 22%, which was the highest proportion and this was followed by The Philippines (19.6%) and China (17.7%). 10% of Thai female school students (aged 13-15) were reported as having had at least one drink in the past 30 days compared to 12.9% in The Philippines and 8.6% in China (WHO, 2011).

As presented above, the issue of alcohol consumption among young people aged 13-15 represents a global issue because of the consequences that reflect on the society and the individual. Following the reports of the WHO it can be observed that alcohol consumption has direct connections with poverty and culture (WHO, 2011). As stated before, in countries like Zambia where girls aged 13-15 are the highest percentage of students who drink alcohol, alcohol consumption is connected to prostitution and HIV transmission. In other regions of the world, alcohol consumption seems to reflect the number of deaths caused by it either through accidents or disease (WHO, 2011). Developing countries are known to have the highest level of alcohol consumption, with Thailand leading the charts with a rate of 22 % among male school students.

Europe is the region with the highest level of deaths caused by alcohol consumption. With regard to this, I present the situation of alcohol consumption among young people in the UK, focusing on England and Scotland because it is the highest in the world and it is possible to learn from this. There are also measures and regular surveys of young people's alcohol consumption in the UK which might be useful to consider for my study as discussed below.

### **1.2.2 Young people and alcohol consumption in England and Scotland**

In England, Donaldson's (2009) national survey estimated that 2.85 million children aged 11–17 have ever consumed alcohol, over a million children consume alcohol weekly, and 486,000 children drink more than once a week. About 500,000 children aged 11–15 had been drunk in the last four weeks (Donaldson, 2009). Donaldson found that the vast majority of young people had consumed their first alcoholic drink at age 15 and that the proportion of children drinking increased with age. Similarly, Currie *et al.* (2008) found in their survey of 15 year olds that 24% of girls and 23% of boys had had their first drink at age 13 or younger.

A report of the Health and Social Care Information Centre which surveyed in 2011 claimed that 45% of young people aged 11 to 15 drank alcohol at least once. 12% of them were reported as having consumed alcohol in the previous week and this was more common in older children (74% of 15 year-olds and 11% of 11 year-olds). Children reported that they drank alcohol at least once a week and the mean intake was 10.4 units. Popular types of alcohol for these young people were beer, lager and cider (Gill *et al.*, 2012).

In 2012 the Health and Social Care Information Centre surveyed the drinking behaviour of secondary school students aged 11 to 15. The findings showed that 43% of students had drunk alcohol at least once. Both genders were equally likely to consume alcohol, increasing with age from 12% of 11 year olds to 74% of 15 year olds. Drinking alcohol in the last week decreased to 10% with similar proportions of boys and girls. Students who had consumed in the last week had drunk an average of 12.5 units, and most alcohol beverage was beer, lager or cider. The commonest ways

of obtaining alcohol was to receive it from parents (19%) and friends (19%). In this survey it is also indicated that 50% of students had been drunk in the last four weeks at least once during that time (Henderson *et al.*, 2013; Fuller and Hawkins, 2014).

Regarding alcohol consumption among young people, in England in 2012, students (aged 11-15) reported that the consequences of drinking alcohol in the last four weeks included feeling ill or sick (40% of students who had been drunk in the last four weeks), vomiting (27%), getting into an argument (23%), damage to clothes (19%) and losing money (18%) (Henderson *et al.*, 2013). These figures increased according to the survey conducted in 2008 by Diment *et al.* (2009) who reported that students aged 11 to 15 reported having felt ill or sick (29%), having an argument (16%), vomiting (13%), having clothing damaged (13%), having lost money (12%), and being taken to hospital (1%). Moreover, Donaldson (2009) indicated that in England, in 2008 over 7,600 children aged 11-17 were admitted to hospital, for conditions directly related to alcohol consumption. According to Henderson *et al.* (2013) who surveyed young people in England aged 11 to 15 years old, the consequences of alcohol consumption were also reported to include: 38% having vomited, 29% damaged their clothes, 26% losing money, 23% having a fight and 18% getting into trouble with the police. Furthermore, when Hibell *et al.* (2009) carried out the 2007 European School Survey Project on Alcohol and Other Drugs (ESPAD) survey of 15 and 16 year olds, he found that boys (11%) and girls (12%) in the UK had engaged in unprotected sex following alcohol consumption.

Regarding the alcohol consumption by young people in Scotland particularly students aged 13 and 15 year olds, Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) (Black *et al.*, 2008; Black *et al.*, 2010) reported a decrease in alcohol intake by 13 year olds from 52% in 2008, to 44% in 2010. Similarly, alcohol intake among young people aged 15 years old decreased from 82% in 2008, to 77% in 2010. The most common alcohol drink was beer/lager/cider. Similar results were found with regards to the common sources of purchasing alcohol in 2008 and 2010 (buying from friends and shops). Furthermore, similar results were found in both 2008 and 2010 in terms of the most common location for students' drinking being at home. The survey also reported the role of the family in young people's drinking: the majority

of 15-year-old boys reported their drinking habits to their families, while 13-year-old boys did not report their drinking habits to their families (Black *et al.*, 2010).

The situation regarding alcohol consumption in the UK, particularly in England and Scotland reveals the fact that young people consuming alcohol represents a problem for developed countries as well, and not only for developing countries like Thailand. With regard to children aged between 11-15 consuming alcohol, it appears to be a regular habit and research showed also that the situation had worsened from 2009 to 2012 according to a survey of Henderson *et al.* (2013). Broadening the knowledge regarding the extent and particularities of alcohol consumption among young people in the UK represents a valuable source of data for comparison and a better understanding of the issue in Thailand. The policies and measures implemented in the UK countries can provide useful evidence for further policies that could be implemented in Thailand. Moreover, the understanding of the SALSUS survey makes me think about the situation of young people's alcohol consumption in Thailand and encourages me to adapt the SALSUS questionnaire to conduct my study.

### **1.3 Alcohol consumption by young people in Thailand**

According to Thailand's statistics of young people's alcohol consumption, the phenomenon appears to be increasing. The following table shows the proportion of alcohol consumption by young people in 2007 and 2011.

<b>Table 1.1 Young people's alcohol consumption situation in Thailand</b>			
<b>Year</b>	<b>Boys (%)</b>	<b>Girls (%)</b>	<b>Overall (%)</b>
2007	(n=4,768,133)	(n=4,562,168)	(n=9,330,301)
11-14 years old	0.66	0.11	0.39
15-19 years old	23.18	1.84	12.74
2011	(n=4,616,184)	(n=4,399,155)	(n=9,015,339)
11-14 years old	0.88	0.01	0.46
15-19 years old	24.56	2.87	13.96

(Source: Thai National Statistical Office, 2007; 2011)

The Thai National Statistical Office has surveyed the characteristic of young people and alcohol consumption in Thailand (Thai National Statistical Office, 2007; 2011). Table 1.1 shows that the proportion of young people who consumed an alcoholic drink increased from 7.35% in 2007 to 8.22% in 2011 particularly in young people aged 11-14 who increasingly consumed alcoholic drink from 0.39% in 2007 to 0.46% in 2011, and from 12.74% in 2007 to 13.96% in 2011 for youths aged 15-19 years old. Boys in all age groups were more likely to drink than girls. Moreover, Vantamay (2009) showed the national survey information that Thai youth aged 15-24 years used alcohol increasingly from 21.6% in 2001, to 23.5% in 2004, and 23.7% in 2006.

This can be compared with a cross-sectional study with upper secondary school students in Nakhon Ratchasima Province which found that 12.59% of students used alcohol (Chaveepojnkamjorn and Pichainarong, 2007), and a survey in 2007 showed that the prevalence of alcohol consumption among young people in the 12 to 19 year-old age group in Thailand being 17.9% of boys and 7.3% of girls. An increase was found in both boys and girls aged 20 to 24 years (59.5% of boys and 15.8% of girls). Both male and female school students were more likely to drink <1 day/month (30.8% of boys and 72.7% of girls) compared with 2-3 days/month (24.9% of boys and 14.8% of girls) and 1-2 days/week (23% of boys and 8.1% of girls) (Assanangkornchai *et al.*, 2010). The commonest drinking-related consequence among boys was getting

involved in fighting while drinking (26.1%), whereas girls had feelings of guilt or remorse (17.5%). Moreover, 19.1% of boys reported having financial problems and 18.2% had problems with work, study or employment opportunities compared to 9.8% of female drinkers. 9.3% of girls reported having physical health problems and 8.2% reported having been in fights. Again, just over half (51%) of boys reported having three or more problems on one drink occasion compared with 31.6% of girls (Assanangkornchai *et al.*, 2010).

Alcohol consumption among young people in Thailand has been affected by the spread of western culture, which has induced an acceptance of drinking alcohol as being fashionable and promoting social relationships (Assanangkornchai *et al.*, 2009). Compared to previous generations, Thai youth today are more likely to value alcohol drinking; this is particularly true of high school students, who often drink prior to completing high school. Furthermore, there is evidence that young people engage in high-risk activities resulting in a variety of problems (Assanangkornchai *et al.*, 2010).

The situation of young people consuming alcohol in Thailand appears to be very much similar to that of young people in the UK. It is evident that alcohol consumption rates are increasing as the habit becomes more and more incorporated within the national culture. Young people follow the example of their older friends and colleagues generating a domino effect of alcohol consumption. The issue appears to be particularly serious among young boys aged 15-19 years.

#### **1.4 Thai culture and alcohol consumption**

In an age of globalization where the whole world is linked together, transnationalism has become a major issue for Thailand. Characterized as 'border crossing,' globalization now permeates almost all aspects of the nation's life - culture, technology, religion, education, and politics (Rush, 2009; Soonthorn *et al.*, 2014). Western culture is accepted by Thai people, particularly those who live in big cities, and then it spreads into the countryside (Mahaarcha and Kittisuksathit, 2013). An impact of modernization is that many Thai people in rural areas have moved to big cities to get a job or higher education. As a result of this, the typical family type has

changed from that of a large extended family to a single family unit. This is very different from the past when several generations lived together in one big household and strong relationships developed between family members. Moreover, the impact of Western culture has also influenced Thai culture, specifically as it relates to drinking behaviour. Most Thai teenagers now drink alcohol because they view the habit as being western, glamorous and civilized (Ninnart, 2014; Mahaarcha and Kittisuksathit, 2013).

Within Thai culture, many Thai people continue to believe that drinking alcohol is normal (Assanangkornchai, 2006; Chaveepojnkamjorn and Pichainarong, 2007). Alcohol is usually part of traditional celebrations and holy rites. Young people's drinking thus usually occurs in common activities, associated with religious and cultural events (Moolasart and Chirawatkul, 2012). Normally, hard workers or labourers buy a small bottle of local colourless distilled liquor or beer before returning home, as a relaxation after work or as relief from muscle aches. Some drinkers drink before dinner to stimulate their appetite and some Thais consume alcohol for medical purposes such as to relieve dizziness or faintness or to improve their blood circulation. Drinking alcohol is a common way of celebrating, particularly when someone has obtained a new property, a new car, or has a birthday or a New Year party. Moreover, alcohol consumption is related to special occasions during the life course. For example, during traditional ceremonies it is an important custom to offer a warm welcome or congratulations by proffering a tray of food and a bottle of an alcoholic beverage to the ancestors and spirits, inviting them to be witnesses or to bless the participants. After the ceremony, the participants are usually encouraged by the host to drink alcohol. When a couple has a baby, relatives and close friends are invited to celebrate by drinking alcohol. It is the same on a wedding day when alcohol is an essential part of the party. At funeral ceremonies, there is a similar indulgence in alcohol. As a sign of hospitality, food and drinks are served after the religious ritual in the evening. During the traditional annual ceremonies, drinking alcohol is generally considered to be an integral part of the events (Moolasart and Chirawatkul, 2012).

To sum up, consuming alcohol is an integral part of the ceremonial and every day life of people in Thailand. The habit of consuming alcohol, although related to the Western



culture for the younger population, has been part of the Thai culture for many generations and represents the main method for relaxation or celebration.

## **1.5 Buddhism in Thailand**

94.6% of the Thai population is predominantly Buddhist (The National Statistical Office of Thailand, 2011) and there are many customs and ceremonies related to Buddhism. These religious ceremonies have been absorbed into Thai traditions and customs. A common practice for Thai Buddhists is the observation of the Five Precepts, giving donations, gaining merit by offering food to Buddhist monks, worshipping the Buddha, listening to *Dharma* talks, chanting and practising meditation (Chamrathirong *et al.*, 2010). The Five Precepts include refraining from the following 5 perpetrations: destroying living creatures, stealing, engaging in sexual misconduct, giving false speech and indulging in intoxicating drinks and drugs, which, in effect, means total abstinence from alcohol and illegal drugs. Alcohol is nevertheless widely used as an important part of the ceremonies and celebrations (Newman *et al.*, 2006).

A difference between the religion and culture of the Thai people can be observed, as although Buddhism advises on the abstinence from alcohol, people use alcohol on a regularly basis for different purposes. Nevertheless, Buddhism is known as a permissive religion compared to others, and this can be seen from the way rules are called, namely precepts and not commandments. Therefore, people have the freedom to interpret these precepts and adapt them to their principles of life. However, there is a distinct lack of studies of the impact of Buddhism on drinking behaviour and the relationship between Buddhism and young people drinking in Thailand (Mahaarcha and Kittisuksathit, 2013).

Although Buddhism provides the moral basis of regulation of behaviour via the five precepts there are also Government policies relating to alcohol control. Despite the long history of alcohol use in Thailand, it was not until 2003 that the National Alcohol Control Committee was set up. The Alcohol Beverage Control Act was passed by Parliament in 2007 (Institute of Alcohol Study, 2007) and developed into the Alcohol

Beverage Control Act in 2008. This aims to reduce alcohol consumption by young people. For instance, Section 29 states that the minimum age for purchasing alcohol is 20 (Alcohol Beverage Control Act, 2008).

## **1.6 The context of the study**

This study was conducted in Thailand's Petchaburi Province, which is located in the western part of Thailand bordering Myanmar. On the east it is close to the Gulf of Thailand. I chose this area because I had worked as a nursing instructor at the Prachomklao College of Nursing in Petchaburi Province. My work provided me with experience of the local health care system and how it is coping with the drinking problem in this particular area. Because I have worked in this province for over 20 years, I am familiar with the people there, including the healthcare teams and school principals and teachers, all of whom I anticipated would cooperate with my research and participate in the data collection process. Moreover, there are a lack of any studies on alcohol consumption in Petchaburi Province, a fact that made me even more interested in doing my research in this particular province (Thai National Statistical Office, 2011). Finally, I hoped to be able to implement my proposed intervention programme in Community C after evaluating it thoroughly during the period of my project.

Petchaburi Province is subdivided into 8 districts, consisting of 1) Mueang Phetchaburi district, 2) KhaoYoi district, 3) Nong Ya Plong district, 4) Cha-am district, 5) Tha Yang district, 6) Ban Lat district, 7) Ban Laem district, and 8) Kaeng Krachan district. The following figure shows the map of Petchaburi Province and districts



**Figure 1.1 Map of districts in Petchaburi Province**

For Phase One, the survey was undertaken in these 8 districts through the provision of self-reporting questionnaires. I provide a detailed account of how I organized the survey in Chapter Four.

As shown in Table 1.1, the greatest proportion of young people drinking in Thailand are aged 15-19 years (Thai National Statistical Office, 2007; 2011). Thus, my sample population comprised secondary school students from this age

group from the schools in these 8 districts. A report of Ministry of Education in Thailand presented the total number of Matthayomsuksa 1-6 (Grades 7-12) students in Petchaburi Province was 9,389 of which fewer than half (4,125 students) were studying in Matthayomsuksa 4-6 (Grades 10-12). According to Thai statistics, only 51.13% of school pupils continue to study in Matthayomsuksa 4 (Grade 10) after they have finished Matthayomsuksa 3 (Grade 7) (Ministry of Education, 2008). The samples were selected using the sampling frame described in Chapter 4. One school was selected from each district, the details of which are summarized below.

School A is located in the city centre and close to a Buddhist temple. It is surrounded by modern buildings, a supermarket and shops, and has good facilities making use of advanced technology.

School B is located in an agricultural area and near the main road. This school is close to rice fields, a Buddhist temple, gardens and an agricultural product market.

School C is located in an agricultural area and close to rice fields and to a Buddhist temple.

School D is located in an agricultural area and near the main road. This school is close to a Buddhist temple and a market for agricultural produce.

School E is located in an agricultural area and near the main road. This school is close to a Buddhist temple and a fishermen's village, which has a lot of foreign labourers.

School F is located close to the Thailand – Myanmar border and is far away from the city centre and in rather a desolate area. This school is surrounded by forest.

School G is located close to the Gulf of Thailand and to a Buddhist temple. This school is near the highway to the southern part of Thailand and close to a famous seaside resort, where there are a lot of tourists.

School H is located close to the Thailand – Myanmar border and to a Buddhist temple. This school is surrounded by forest.

For Phase Two, School C, which is situated within Community C, was identified for the participatory action research inquiry using logistic regression as described in section 1.7 below.

## **1.7 Research aim and questions**

This study aims to gain a detailed knowledge of the alcohol consumption behaviour of young people in Petchaburi Province, using a cross-sectional survey across the 8 districts. I wanted to understand the perspectives of partners in community C towards the young people's behaviour and alcohol consumption. Hence, I framed the following research questions:

**Question 1:** What are the characteristics of alcohol consumption behaviour of young people (age 15-18) in Thailand? This question is designed for the first phase which comprised a cross-sectional survey study carried out through a self-administered questionnaire, developed from SALSUS in 2008.

**Question 2:** What are community stakeholders' experiences of, and perspectives on, the alcohol consumption behaviour of young people? This question is designed for the second phase of my study which comprised qualitative data collection by means of Participatory Action Research (PAR) focus groups and in-depth interviews.

Seeing the situation from the perspective of as many community stakeholders as possible is key to development of an effective intervention programme (Koch and Kralik, 2006). Therefore, my long term aim is to work with Community C to develop an intervention which will be piloted in School C. It is hoped that eventually following evaluation such an intervention programme will be adopted as an appropriate prevention strategy to promote young people's health in relation to alcohol use throughout the Province and eventually Thailand.

## **1.8 The structure of the thesis**

In Chapter Two, I review the literature to explore the current knowledge in the field and identify gaps in this knowledge. The content of the review includes the concept of alcohol consumption by young people in western countries, alcohol consumption by young people in Thailand, consequences of drinking alcohol in young people, factors affecting young people on drinking, prevention strategies, Buddhism, culture and alcohol use, and the national alcohol policy. The various themes from this extensive literature review encouraged me to understand how the SALSUS tool would fit in the Thai context and influence my adaptation of the SALSUS tool for the survey questionnaire and interview question guidelines. The literature review also enabled me to refine my study objectives and support my discussion of the findings in Chapter Eight.

In Chapter Three I discuss in detail the methodological issues and research approach pertaining to the study. The theoretical perspectives underpinning my study are child development theories which help me understand how the young people's development relates to drinking behaviour. Then, I have applied the Ecological Approach (McLeroy *et al.*, 1988), which includes a variety of levels, namely, intrapersonal, interpersonal institutional or organizational, community, and public policy. Moreover, in this chapter I explain how to apply the Ecological approach to my study. In the final section of this chapter I will explain the method of Participatory Action Research which I have organized for Phase Two to collect qualitative data.

Chapter Four describes the research design and methods for Phase One: the Survey. This chapter describes the process of undertaking the survey and discussion of the ethical implications relating to the decision about whether or not to participate.

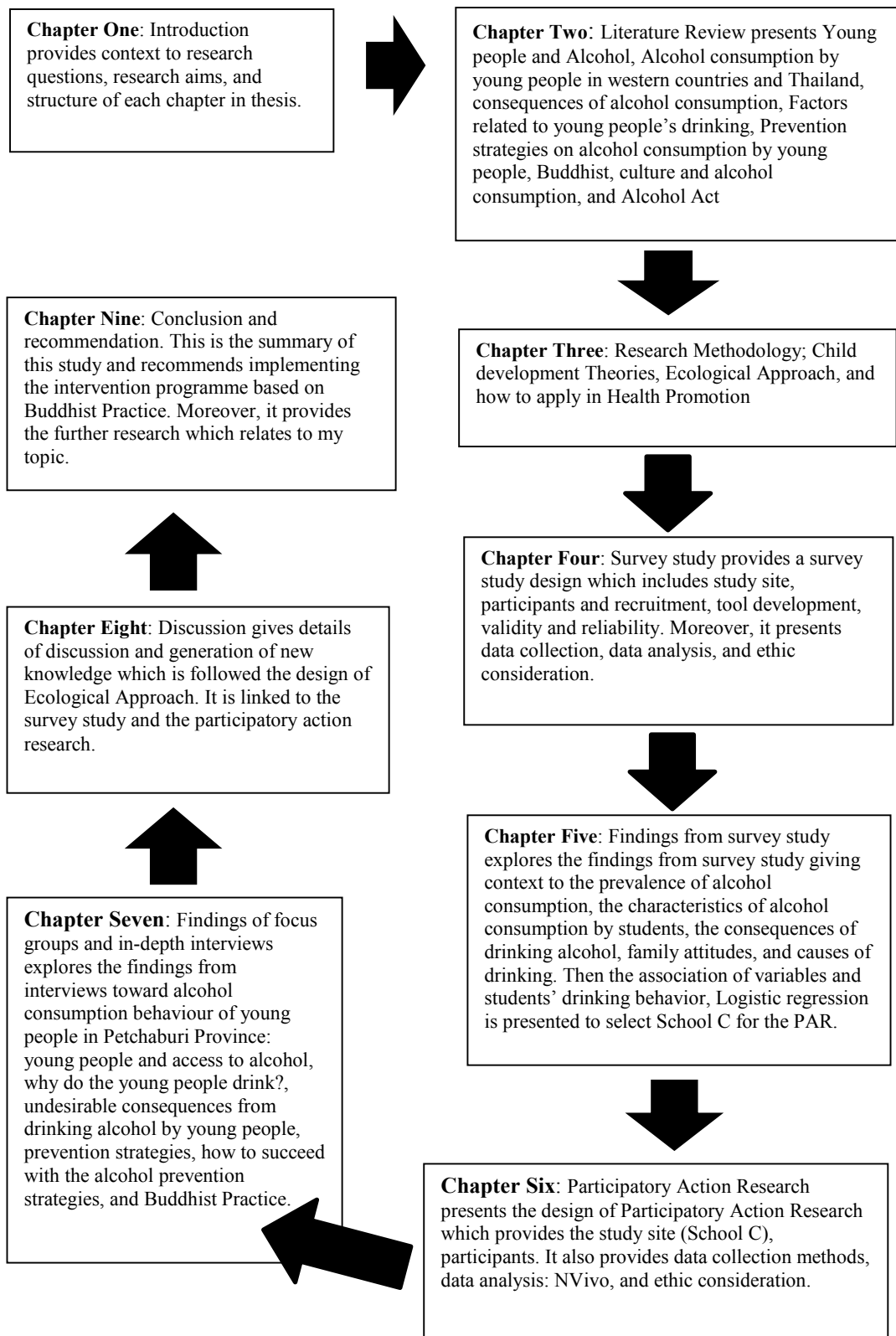
Chapter Five is divided into three parts. In part one I present the survey findings and descriptive statistics. The topics covered in this part are: the demographic profile of informants, location of students' drinking, occasions for drinking, who young people drink with, description of students' family members and alcohol, the prevalence and characteristics of alcohol consumption by students, consequences of drinking alcohol, where students usually buy alcohol, family attitudes to drinking, and causes of drinking. In part two I present data relating to the association between variables. The association between young people's drinking behaviour and demographic information, data relating to family members' drinking, students' drinking patterns, sources of buying alcohol, and family attitude are presented. In the final part, I present the findings of the logistic regression analysis that was used to select a school for Participatory Action Research in Phase Two.

Chapter Six presents the research design and methods used in Phase Two using a Participatory Action Research (PAR) approach. Participants from a range of stakeholder groups were recruited for focus groups and in-depth interviews. Thematic data analysis was carried out using NVivo to organize the data.

In Chapter Seven, I present the findings of the Participatory Action Research. This chapter offers a full account of the findings and of the emerging major themes. These themes include alcohol access by young people, why the young people drink, the consequences of alcohol consumption by young people, how to prevent alcohol consumption by young people, the management of alcohol consumption control for young people, and Buddhist Practice for controlling the drinking of young people. Within each theme there are various sub-themes that I take forward to discuss in Chapter Eight.

Chapter Eight presents the discussion of the findings and the generation of new knowledge. The ecological approach is used as a lens through which to understand the findings presented in Chapters Five and Seven.

Chapter Nine is the concluding chapter and provides recommendations. This is the summary of this study and recommends implementing the intervention programme with the students in School C based on Buddhist Practice. The following diagram summarises the content of each chapter and the process by which the data were collected and analysed to generate the findings, conclusions and recommendations from undertaking my research.



**Figure 1.2 Diagram of the process of doing research with nine chapters**



## **Chapter 2**

### **Young people and alcohol consumption**

#### **2.1 Introduction**

This chapter presents information to support a general understanding in relation to the topic of young people<sup>1</sup> and alcohol consumption. The literature review provides data regarding the prevalence of alcohol use among young people and consumption levels in various regions including the UK, Thailand other countries worldwide. Then I will present the negative consequences of alcohol consumption by young people, and discuss the motives and potential family influences of young people's drinking habits. Following this information concerning current prevention strategies to reduce alcohol consumption by young people including policy, family, school, and community levels will be critiqued. The subsequent section focuses upon the Buddhist culture particularly in Thailand, including the history of Buddhism, and the culture of alcohol use. It then discusses the potential impacts that religion can have on alcohol consumption by young people. The final section discusses alcohol policies, presenting policies by both the World Health Organisation (WHO) and Alcohol Act in Thailand (Alcohol Beverage Control Act, 2008).

#### **2.2 Search parameters**

This selective review of the literature was carried out using the online databases listed below. A manual search of the University of Edinburgh library was also carried out for relevant text books and journal articles in relation to alcohol consumption behaviour and young people.

Web of Knowledge

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<sup>1</sup> The term "young people" are interchangeable with the word "students", "children", "youth", "teenager" and "adolescence" in the text.

Web of Science

Web of Science Core Collection

EBSCOhost

CINAHL

CINAHL Plus- Cumulative Index to Nursing and Allied Health Literature

Google

MEDLINE

BioMed

PubMed

### **2.2.1 Key search words**

This research is about the alcohol consumption behaviour of young people. The following keywords were identified as best for searching the literature: young people, alcohol consumption behaviour, alcohol prevention strategy, factors associated with young people's drinking behaviour, alcohol policy, child development theory, Ecological approach, health promotion, culture and alcohol, Buddhist practice. A total of 1,265 articles and text books were identified which included the aforementioned keywords. The papers were first examined through the reading of their titles and abstract. After reading the full texts, 438 articles and text books were chosen as being relevant to the aims of research.

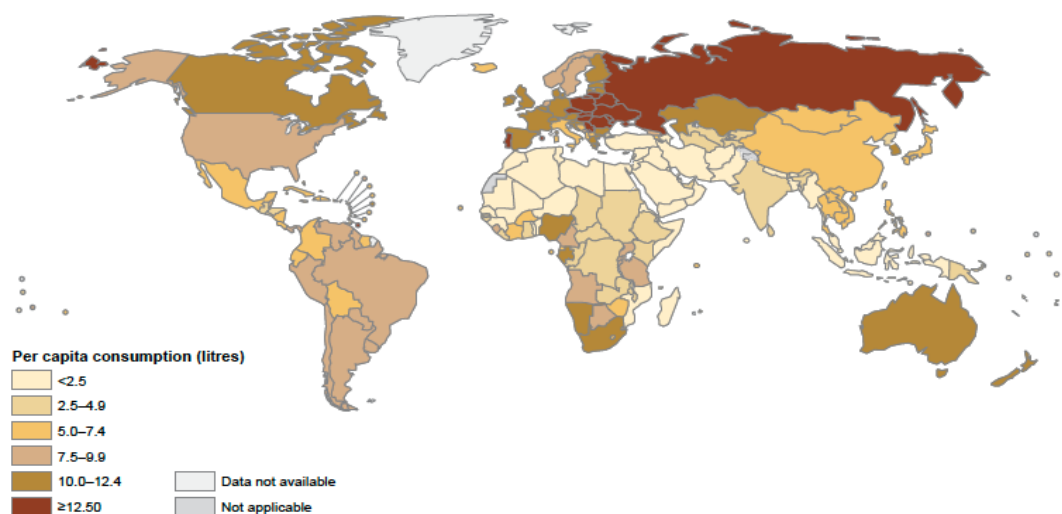
Following section I will present the details of the topic that I stated in Section 2.1.

### **2.3 Global alcohol consumption among young people**

Alcohol is widely consumed throughout the world. According to a World Health Organization report, the worldwide per capita consumption of alcohol per individual

(aged 15 years old or older) reached about 6 litres of pure alcohol in 2005 (WHO, 2011). Regarding young people's alcohol consumption, the report noted that drinking trends were increasing in both under-age youths and among 18–25 year olds. The research also stated that the rate of alcohol consumption by youths continued to increase in the years after high school (Chartier, Hesselbrock and Hesselbrock, 2011). For instance, in Europe 34% of 15-year-olds reported being 'drunk' at least 10 times throughout the previous 12 months in Denmark, 25% in the United Kingdom, 15% in Sweden, and 11% in Germany (Järvinen and Østergaard, 2008). In terms of the most commonly consumed alcoholic beverage, countries differed according to preferences for types of alcohol. Overall in Europe, beer, wine and spirits were the top three most consumed beverages (WHO, 2011). These countries do not identify local alcohol such as is found commonly in Thailand and is consumed during ceremonies and is often the first type of alcohol that a young person will experience (see Chapter Seven). The Figure 2.1 shows the per capita consumption alcoholic beverages.

**Figure 2.1: Per capita consumption alcoholic beverages**

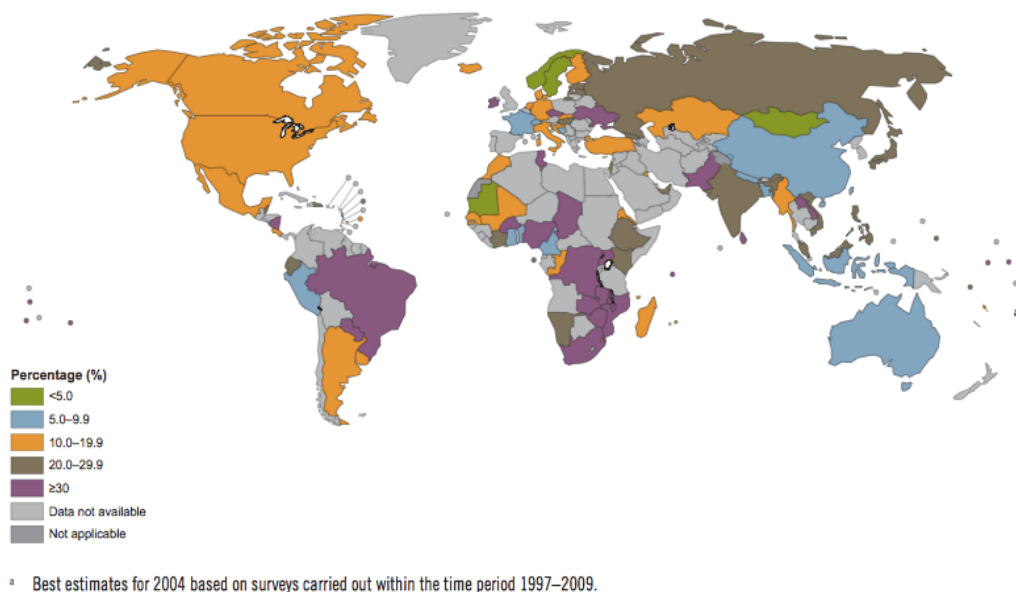


Source: World Health Organization (2014)

### 2.3.1 Drinking prevalence and patterns

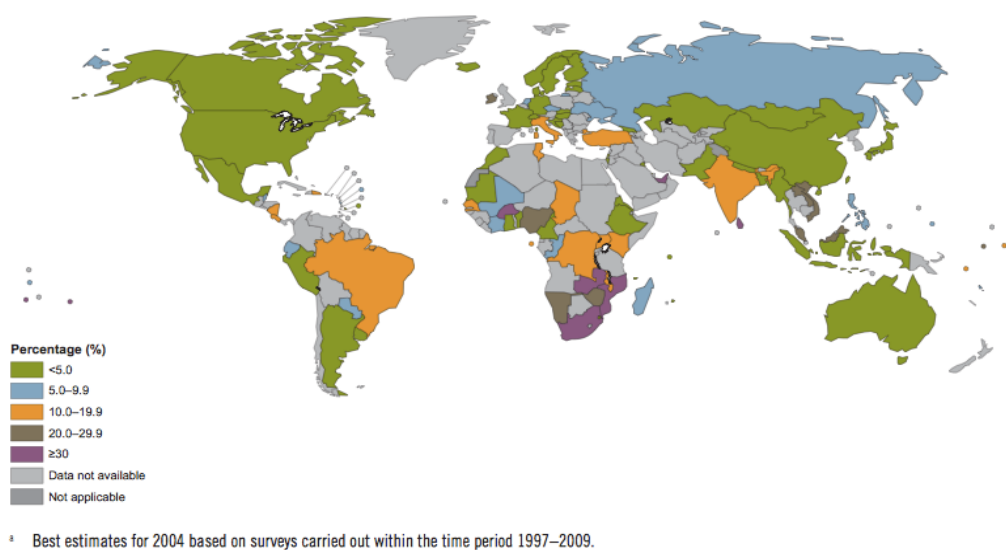
Drinking motives play a significant role in shaping the drinking patterns of adolescents. When people make a conscious decision whether or not to consume alcohol, it involves a combination of emotional and rational processes (Kuntsche *et al.*, 2006). According to the World Health Organization's report (WHO, 2011), patterns of alcohol consumption were correlated to the amount of alcohol consumed, including abstention and heavy episodic drinking. Abstention was categorized into three different groups (i) lifetime abstainers: people who never drink alcohol; (ii) former drinkers: people who have previously drink alcohol but had not drunk in the past year; and (iii) past year abstainers: people who had not drunk alcohol in the past year. Heavy episodic drinking referred to individuals who consumed a minimum of 60 grams pure alcohol at least once a week. Figures 2.2 and 2.3 show the prevalence of heavy episodic drinking of both males and females worldwide.

**Figure 2.2 Prevalence of heavy episodic drinking of males in 2004**



Source: World Health Organization (2011)

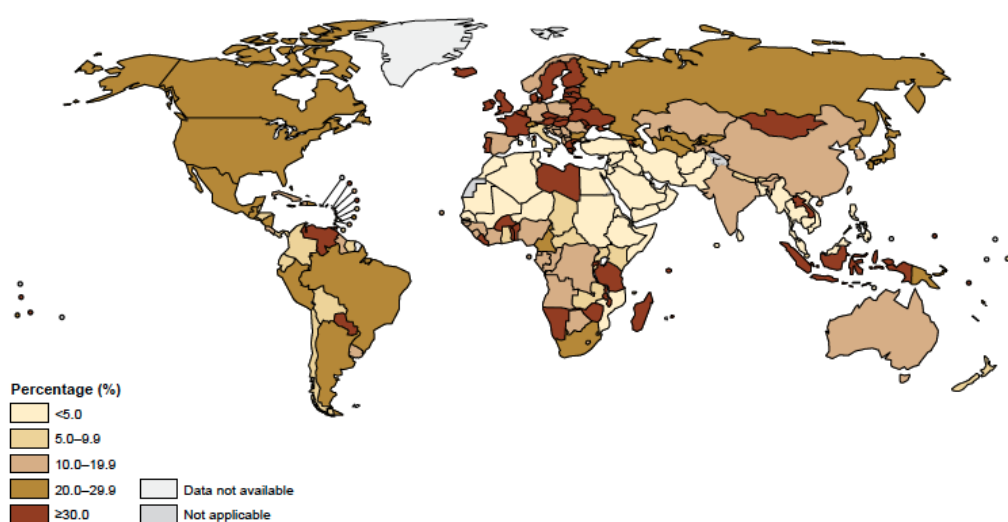
**Figure 2.3 Prevalence of heavy episodic drinking of females in 2004**



Source: World Health Organization (2011)

The report of WHO in 2014 shows the heavy drinking of current drinkers age 15 years old and over also in European region and America and follows with African region and South Pacific region (Figure 2.4).

**Figure 2.4 Prevalence of heavy drinking among current drinkers (15+ years), 2010**



Source: World Health Organization (2014)

Many researchers have reviewed worldwide drinking patterns. They have found differences in drinking patterns between adolescents and adults, between males and females, and between different ethnic and religious groups (Ahlström and Österberg, 2005). Ahlström, Bloomfield and Knibbe (2001) demonstrated that on average, females consumed less alcohol than males. In many countries, males accounted for more than 70% of the total alcohol consumption. In addition, the proportion of male alcohol consumption in some developing countries was even higher. In China, for instance, males accounted for approximately 95% of all alcohol consumption (Babor *et al.*, 2003).

This section discussed the prevalence and pattern of alcohol consumption by young people worldwide, and demonstrates that it is a global problem. This supports my study's premise that alcohol consumption by young people is a significant problem that many countries are concerned about. My study is necessary due to the ever-increasing alcohol consumption by young people worldwide leading to many problems including health, social, and economic problems, with specific challenges in Thailand.

## **2.4 Alcohol consumption by young people in Britain**

It is especially important to review alcohol consumption by young people in Great Britain because it is said to have one of the highest rates of alcohol consumption in first world countries (Neild, 2013). Knowledge of alcohol consumption in Britain will also support my research when comparing Britain's alcohol consumption with trends of alcohol consumption in Thailand (the study site). The comparison between the two countries is relevant for the research because the developed nations of the UK are confronted with a similar issue as Thailand, a developing country. The similarity between the two is the prevalence of alcohol use among young people and the cultural background of consuming alcohol as a method of relaxation or celebration. Since a number of measures and policies have been implemented in Britain over the past years, the experience there can be used in order to identify the measures that prove to be efficient for Thailand as well. This chapter reviews these measures and the extent to which the goal of reducing alcohol consumption has been achieved. The information below will explain the situation.

The prevalence of young people drinking alcohol in the Britain has changed tremendously over the years. The number of units consumed per week has significantly increased. The proportion of female drinkers has also considerably increased (Harrington, 2000, Beuret, Corbett and Ward, 2012).

Prevalence and patterns of drinking have changed in response to societal transformations and shifts. Patterns of alcohol consumption largely depend on social contexts. According to Kneale (2001), the Temperance Movement emphasised a positive relationship between poverty and drinking. The Temperance Movement became popular in Britain in the 19th century and it promoted reducing or completely abstaining from alcohol. The movement led to the creation of the British Association for the Promotion of Temperance in 1835 and it was quickly taken on by working class movements. A prohibition law has never been introduced because the principles of temperance support the idea that abstinence should occur as a result of personal moral values and not of a restrictive law (Berridge, 2005). The Temperance Movement emphasised that prevention programmes should be implemented to check substance use including tobacco and alcohol.

Organisations have been established which aim to spread awareness of the harmful influence of drug and substance abuse. These organisations also focus on different social contexts. For instance, the National Centre for Social Research and the National Foundation for Educational Research (NCSR and NFER, 2010; Gunning *et al.*, 2010) which undertook a survey on behalf of the NHS Information Centre for health and social care including a core set of questions on smoking, drinking and drug use, aims to educate children and young people at an early age about the adverse impacts of alcohol (Velleman, 2009). The emphasis of the 2006-2009 survey carried out to investigate young people's behaviour was on smoking and drinking although it still contained some questions on drug use (NCSR and NFER, 2010).

Attitudes toward alcohol are also shaped by individual religious and ethnic backgrounds (Francis, 1997). For instance, all the main religions in South Asia, namely Hinduism, Jainism, Buddhism and Sikhism, condemn the use of alcohol (Harrop *et al.*, 2006). However, young people who originate from these countries who now live in the

UK may not abstain from alcohol in the UK, as they would in their native countries. Abstinence from alcohol is widespread amongst Muslims (McKeigue and Karmi, 1993), yet many Muslim men today now consume alcohol especially when they are out of their own country (Velleman, 2009).

One of the first studies to identify patterns of alcohol consumption was conducted by Cochrane and Bal (1990). This community survey collected data from participants from random samples of 200 each of English, Sikh, Muslim and Hindu men in Wolverhampton and Birmingham, all matched for age (17-69 years). The study concluded that overall, Muslim men were people who drank the least amount of alcohol, Hindu men followed. Sikh and white men reported approximately the same level of alcohol intake. However, more Sikh than white men consumed alcohol regularly. The majority of Muslim men (90.5%) reported that they never consumed alcohol or had not consumed alcohol in the past year. However, most respondents reported that they consumed alcohol once or twice per week. The review of the literature suggested that there was a continuous variation in alcohol consumption by youth from different ethnic backgrounds.

Smith and Foxcroft (2009) provided a comprehensive overview of alcohol consumption patterns in young people in the UK. The amount of drinking increased among all age groups. However, the increase in the number of young people aged between 16 -24 who consumed alcohol was the most substantial. Thus, the prevalence and patterns of alcohol use indicates a higher consumption by young people (Velleman, 2009).

Williams, Davies and Wright (2010) conducted research on the alcohol consumption of young people aged 9-17 years in England. They developed a questionnaire from a range of validated measures and used this to explore young people's and their parents' perspectives on alcohol consumption. The findings revealed that 49% of young people claimed that they drank alcohol at least once<sup>2</sup>. This figure was similar to the finding that 50% of parents reported that they thought that their child had ever drunk alcohol. Incidence of drinking reported by the young people increased with each school year,

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<sup>2</sup> A whole drink not just a sip



from 8% for year 6 participants through to 90% in year 13. Drinking alcohol was reported rarely by young people in years 6 to 9. Around one -fourth young people in years 10-11 drank at least once a month, and this increased to over half of young people in years 12 and 13. About drinking behaviour over the previous seven days, 15% of the young people claimed that they had a drink compared with the 9% of overall who drank at least once a week. This suggests that there may be some under-reporting of drinking behaviour by the young people.

The findings on young people also showed that the most popular drinks were beer/lager/bitter/cider while the most popular drink among girls was alcopops (Williams, Davies and Wright, 2010). On average, they had consumed 2.6 units of alcohol over the past seven days, and the number of units consumed varied by school year from under 4 units among years 7-8 to over 20 units among years 12-13. One unit stands for 10 ml of pure alcohol (Williams, Davies and Wright, 2010).

The total 2017 both young people and parent samples indicated that the most common reason for alcohol consumption was due to peer pressure (54%). However, about their own behaviour the young people most frequently said it tastes nice (41%). When asked about the consequences of drinking heavily, 58% reported knowledge of risks to their own health followed by the potential of becoming involved in crime or violence (27%).

In terms of the location where alcohol is consumed, 62% of the young people reported that it was in their own homes, while 41% that it was in other people's homes. Fewer young people claimed that they usually consumed alcohol in a pub or bar (17%) and 11% at a club or disco. In this case, 53% of young people aged under 18 said that they were given alcohol by their parents, while older children got alcohol from friends or purchasing it themselves. Most young people (56%) thought that their friends consumed more alcohol than them, and 87% of children who drink said that their parents knew that they drank alcohol.

The information presented above offers valuable data regarding the particularities of alcohol consumption among young people in Britain. The cultural context described in the findings, particularly in relation to the parents' perspectives on when it is acceptable for young people to drink, is significantly different to that in Thailand

where parents do not allow young people to drink under the age of 20 years. These data helped me to understand what needs to be asked in any measure that I will use to explore young people's drinking in Thailand. Moreover, this information assisted me to consider the use of Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS), and guided my modification of it as discussed in Chapter Four.

Fuller and Hawkins (2014) undertook a survey of smoking, drinking and drug use patterns among young people in England in 2013. Data were gathered through the use of a self-completion paper questionnaire which was distributed to 5,187 pupils in 174 schools in England. This survey contains information on young people's alcohol consumption between the ages of 11 and 15 in secondary schools in England, as a reference point for health issues relating to alcohol use and misuse. '*Smoking, drinking and drug use among young people in England*' is an annual survey carried out on behalf of the Health and Social Care Information Centre.

The key findings from Fuller and Hawkins's (2014) survey are as follows: 39% of young people claimed that they drank alcohol at least once. There was an equal number of boys and girls who had consumed alcohol. The proportion of students who drank alcohol at least once increased with age (from 6% of 11 year olds to 72% of 15 year olds). Over the past 10 years the evidence shows a decreasing trend in the prevalence of young people drinking in the week prior to data collection. Fuller and Hawkins found that the proportion of young people who had consumed alcohol in the last week increased with age from 1% of 11 year olds to 22% of 15 year olds. For those students who had consumed alcohol in the past week, the mean amount of units was 8.2. These figures suggest the effects of growing up on the probability of consuming alcohol in young people. The increase rates reveal that despite measures taken to inform young people about the negative effects of consuming alcohol, they continue to drink.

The most popular type of alcoholic drink for boys was beer, lager or cider. The girls reported drinking a diverse range of alcohol with no particular form taking precedence. This is in contrast to SALSUS which girls preferred to consume alcopops (for 13 year girls) and spirits (for 15 year girls) (Black *et al.*, 2008; Black *et al.*, 2010).

In the previous year, Henderson *et al.* (2013) distributed the '*Smoking, drinking and drug use among young people in England*' survey to 7,589 children aged 11 to 15 from 254 schools throughout England in 2012. The findings revealed that 43% of pupils had consumed alcohol at least once with equal levels for boys and girls. The proportion of young people who drink alcohol increased from 12% of 11 year olds to 74% of 15 year olds. In this case, young people who drank alcohol in the previous week increased from 1% of 11 year olds to 25% of 15 year olds, and the average amount of alcohol consumed was 12.5 units.

Henderson *et al.* (2013) also identified that male pupils were more likely to drink beer, lager or cider whereas girls were more likely to drink spirits, alcopops or wine. Younger students usually drank with family members; on the other hand, older students usually drank with friends. There was an increase since 2006 with regard to the proportion of students who usually drink at home or in other people's homes or at parties with friends, and a reduction of students who drink outside. Drinking outside (on the street, in a park or somewhere else) was exposed to public and illegal. 50% of students who had consumed alcohol in the previous month reported that they had 'been drunk at least once' during that time, and 61% of them had 'deliberately tried to get drunk', whilst 39% did not.

In terms of the causes of drinking alcohol, students said that the behaviour and attitudes of their families strongly influenced them to drink. Students tended to drink if they were living with someone who drinks. 83% of students who came from households where alcohol was not consumed reported that they had not consumed alcohol themselves. In contrast, 30% of students who lived with 'three or more drinkers' had consumed alcohol themselves. Similarly, students who thought that their families did not like them drinking were less likely to consume alcohol than students who thought that their families did not mind if they drank (87% of students who felt that their parents would disapprove compared with 28% who thought that their parents would not mind). These findings prove the influence that family has on the drinking behaviour of children. The environment represents a significant risk factor for alcohol consumption because children's behaviour is mostly influenced by their family and friends.

According to students' beliefs about why young people of their age drink alcohol, students who have never consumed alcohol thought that young people drink because of social pressures. They want to 'look cool in front of their friends' (77%), and they also thought that their friends put pressure on them to drink alcohol (61%). Students who drink alcohol said that people drink to be sociable with friends (66%), and alcohol gives them a rush or buzz (68%).

The most common methods by which young people obtained alcohol were 'to be given it by parents or guardians' (19%), and 'to be given it by friends' (19%). The most common source of alcohol for younger students was to be given it by parents or guardians. In contrast, the older students usually obtained it from friends (42%) followed by parents (35%). With regards to the location for drinking, younger students were more likely to drink at home (64%) than older students, whilst older students were more likely to drink at someone else's house (55%). In this case, students who currently consumed alcohol said that they usually drank with their parents or with friends of both sexes (54% of boys and 50% of girls respectively).

The review of alcohol consumption by young people in Britain is useful for this study for at least two reasons. First of all, since Britain is one of the leading countries with regards to alcohol consumption (Neild, 2013), such a review provides a clearer understanding of the alcohol consumption patterns among UK youth. As previously stated, the issue of alcohol consumption among young people is a global problem. Understanding the particularities of alcohol consumption in the UK helps to create a general perspective on the issue and to understand the extended effects of drinking on the entire community. Secondly, it provides a framework for the analysis of alcohol-related behaviour in Thailand. The same variables described in the research above (age, gender, social context, religious and ethnic background, type of beverages) were considered for the analysis of the alcohol consumption patterns of young people in Thailand carried out in the present study.

## **2.5 Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)**

The previous section presented studies of alcohol consumption of young people in Britain. In this section I will give data on the alcohol consumption of young people in Scotland, where my university is located. Furthermore, my questionnaire for collecting data in my survey was modified from the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS), which studied the characteristics of school students including smoking, drinking and drug use. The SALSUS questionnaire is very useful and suitable for my study because it indicates the alcohol consumption behaviour of students who are studying in secondary schools, and the questionnaire can clarify the characteristics of the participants.

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) (Black *et al.*, 2008; Black *et al.*, 2010; Dodds *et al.*, 2014) reported substance abuse including smoking, drinking alcohol, and drug use among Scottish school students. I shall present the survey's data about drinking among young people (aged 13 years and 15 years). The sample size was 10,063 in 2008, 37,307 in 2010, and 33,685 in 2013.

The survey reported a decrease in alcohol intake by 13 year olds from 52% in 2008, to 44% in 2010, and 32% in 2013. Similarly, alcohol intake among young people aged 15 years old decreased from 82% in 2008, to 77% in 2010, and 70% in 2013.

However, the proportion of students consuming alcohol in the previous week increased from 11% in 2008 to 14% in 2010 among 13 year olds, and from 31% to 34% among 15 year olds. The proportion decreased in 2013 with 19% of young people aged 15 years old and 4% of 13 years old.

The most commonly consumed drink for boys in both age groups was standard strength beer/lager/cider. There was a slight decrease from 80% in 2008 to 76% and 75% in 2013 of 13 year old boys in 2010, in contrast, there was a slight increase from 82% in 2008 to 85% in 2010 and then slightly declined in 2013 to 82% of 15 year boys. Similarly with 13 year old girls, the most common alcohol drink was also normal

strength beer/lager/cider (66%) which was different to results in 2008 and 2013 when girls preferred alcopops (78% in 2008 and 59% in 2013). On the other hand, spirits and/or liqueurs were common for 15 year old girls (73% in 2010) which decreased from 77% in 2008 and slightly increased in 2013 to 76%.

Similar results were found with regards to the common sources of purchasing alcohol in 2008, 2010 and 2013 (buying from friends, relatives and shops). Buying from a friend was the most popular: 28% of 13 year olds and 46% of 15 year olds in 2013, 13% of 13 year olds and 28% of 15 year olds in 2010, and 23% of 13 year olds and 32% of 15 year olds in 2008. Furthermore, similar results were found in both 2008, 2010 and 2013 in terms of the common locations for students' drinking, which were either at their home, someone else's home and/or a party. For the consequences of drinking, most students of both groups reported that the common effects were: had an argument; had a fight; been admitted to hospital overnight; and visited an A&E department. In 2013 the common effects were: had an argument and vomited.

The survey also covered the role of the family in alcohol consumption. The majority of 15-year-olds (43% compare with 31%) reported their drinking habits to their families and their family 'didn't mind them drinking', while the majority of 13-year-olds (34% compare with 23%) did not report their drinking habits to their families. The authors concluded that the 13-year-olds considered that their families would never allow them to drink (Black *et al.* 2010). In 2013, 70% of 13 year olds and 76% of 15 year olds had been allowed to drink at home (Dodds *et al.*, 2014).

## **2.6 Alcohol consumption among young people in Thailand**

In Thailand, alcohol use has increased dramatically as a result of intense marketing and the manufacture of a sweet fruit beverage promoted for sale to adolescents (McClatchy, 2011). Alcoholic products can generally be produced in local communities and young people have easy access to alcohol. This section aims to present the history of alcohol in Thailand using data extracted from research papers, official statistics, and policy documents that focused on the issue of alcohol

consumption in Thailand. Finally, the drinking pattern of young people in Thailand is reviewed as well as the factors behind drinking.

### **2.6.1 Alcohol history in Thailand**

Thailand has a long history of alcohol consumption. It was said that Chinese immigrants taught Thais to produce spirits during the period 1350–1767 (Thamarangsi, 2006). Furthermore, Chinese immigrants were the first authorized holders of a government monopoly that supplied alcohol in that period (Phaisal Wisalo Bhikkhu, 1984 cited in Thamarangsi, 2006). Records showed that alcoholic beverages were common in Chinese society. Thus, the Chinese drinking culture affected the drinking patterns of Thai citizens. Alcohol use became more common in Thailand during the '*Ratanakosin*' era (after 1782). Thailand had alcohol regulations in place that forbade production in households and established a monopoly system for production, business and tax systems during King Rama I's reign (1782-1802) (Thamarangsi, 2006).

### **2.6.2 Alcohol use in Thailand**

As reported by the World Health Organization, the top three countries among ASEAN<sup>3</sup> countries that consumed the most alcohol consist of Thailand, Laos and the Philippines (WHO, 2011). North East Thailand has the highest percentage of people consuming alcohol (40%), followed by 23% in the North and 21% in the central part (excluding Bangkok). Bangkok itself has about 1.3 million drinkers or about 8% of Thai people (Thai PBS, 2014). The Centre for Alcohol Studies (CAS, 2007) reported that there were approximately 17 million drinkers in Thailand in 2013, which was about 31.5% of the Thai population aged 15 years old and over (Thai PBS, 2014). The result also emphasized that Thai males consumed alcoholic beverages more than females did, as only 3 million out of 17 million drinkers were female. The report made three age group distinction: 15-24 years old, 25-59 years old, and over 60 years old. Results indicated that adults aged between 25 and 59 years old were the highest consumers of alcohol,

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<sup>3</sup> Association of Southeast Asian Nations

accounting for 13.1 million or 77%, followed by 15% of Thai adolescents (Thai PBS, 2014).

### **2.6.3 Drinking patterns of young people in Thailand**

In a review of the literature, Nixon and McClain (2010) found that when young people consumed alcohol during puberty, it was more likely that they would become alcoholics later in life. According to the patterns of alcohol use in Thai households (29 provinces) in 2007 (Assanangkornchai *et al.*, 2010), findings revealed that differences in age and gender correlated with differences in drinking patterns. Young adults (20-24 years old) and adults (25-44 years old) consumed more alcohol than young people (12-19 years old). Males consumed more than females and had higher percentages of alcohol-use sicknesses and alcohol-related problems. There were 17.9% of boys and 7.3% of girls aged between 12-19 years old who were current drinkers. Furthermore, they tended to drink more when they reached young adulthood as the outcome specified that current alcohol use among young adults (20-24 years old) was 59.5 % among males and 15.8% among females. The researchers also pointed out that 24.9% of boys aged between 12 and 19 years drank 2-3 days per month and 23% drank 1-2 days per week. On the other hand, girls consumed alcohol less often than boys, at 14.8% and 8.1% retrospectively. Nevertheless, the research found that modern-day Thai females drank more than women did in the past (Assanangkornchai *et al.*, 2010).

Assanangkornchai, Mukthong and Intanont (2009) studied the prevalence and patterns of alcohol consumption of high school students in 40 provinces in Thailand. A survey was undertaken using a self-administered questionnaire of 50,033 students in Grades 7, 9, 11 (students aged from 13 – 18 years) and in level 2 of the vocational schools (students aged between 16-17 years). Findings showed that most boys and girls (10.6% of boys and 7% of girls) started drinking at aged 15 years and that overall, 36.2% started drinking at age 14 years. Overall, 7,093 of 50,033 students reported that they had drunk in the previous 30 days, of which 3,832 students reported drinking more than 3 times in the previous 30 days, 3,008 students reported as binge drinking and 5,869 students were drinking until intoxicated. The majority of those students drank once or twice (43.9% of boys and 57.5% of girls), and 7.1% of boys and 1.7% of girls



drank almost every day (>20 times in 30 days). Regarding the location of students' alcohol consumption, the two common places were at a party (41.8%) at friends' or cousins' homes and their own home (40.1%). Both genders spent on average up to 15 minutes on purchasing alcohol beverage to drink without being checked for their identification. The study identified that girls' frequency rates of past-year drinking was 14.5%, in the previous 30 days was 3.7%, and drinking until intoxication was 7.2% while in boys the figures were 25.5%, 9.5%, and 17.3% respectively.

Comparison with another survey of substance use is useful. Assanangkornchai *et al.* (2007) carried out a study of high school students in Grades 7, 9, and 11 and vocational school students in year 2 in southern Thailand from 2002-2004. The sample was 8,708 students in 2002, 12,148 students in 2003, and 9,155 students in 2004. Findings were that students drank alcohol in the previous 30 days with 19.3%, 17.3%, and 15.2% in the respective years. The reported rate of drinking alcohol by boys and girls in vocational school year 2 was higher than in the school students (45.34%, 51.09% and 50.73% of boys compared with 21.19%, 15.58%, and 19.24% of girls). This trend was similar to the findings of the same authors' research in 2009 (Assanangkornchai, Mukthong and Intanont, 2009).

Regarding factors behind alcohol consumption, Chaveepojnkamjorn and Pichainarong (2007) who carried out research with 850 students in upper secondary school (aged 15-18 years) in Nakhon Ratchasima Province noted that Grade Point Average (GPA), monthly spending, and educational level were significantly related to alcohol consumption in Thai students. Males who had a poor school performance had more likelihood of alcohol use than those with a good academic result. Moreover, both sibling and peer alcohol consumption were associated with hazardous alcohol consumption among students.

In summary, the findings of these studies indicate that boys drink more frequently than girls. However, it seems that both boys and girls start drinking at similar ages, from age 14-15 years. It may be that these patterns of early and frequent alcohol consumption lead to an increased risk of alcoholism in adult life (Nixon and McClain 2010).

## **2.7 Consequences of alcohol consumption for young people**

An excessive use of alcohol is hazardous and harmful for young people and society (WHO, 2012). Alcohol misuse among young people greatly enhances the risk of youth violence. Youth violence is a multi-dimensional term that includes bullying, sexual aggression, gang violence and violent assaults in pubs, nightclubs and bars (WHO, 2012).

The victims and perpetrators are young people who misuse alcohol. This results in devastating outcomes. According to WHO (2012), an average of 565 people aged between 10 to 29 years old around the world die every day due to interpersonal violence related to the consequence of alcohol use.

Eklund and Klinteberg (2005) studied the personality characteristics of young people in 8th grade in a medium sized Swedish community. Data from males (n=414) and females (n=552) were collected using self-reported violent behaviour and risky alcohol use questionnaires. Findings showed that young people exhibiting anti-social behaviour were more likely to drink excessively. The highest occurrence of alcohol consumption and frequency of intoxication were reported with young people who were characterized by more serious non-violent delinquency or by violent delinquency. Young people with maladjusted behaviour or occasional minor delinquency reported drinking less amounts of alcohol (Eklund and Klinteberg, 2005).

### **2.7.1 Consequences of drinking among young people in the UK**

The UK has experienced a gradual increase in deaths caused by liver disorders particularly women. In 2011/2012 around 49,500 people in England were admitted to hospital with alcoholic liver disease and 36,200 people with the toxic effects of alcohol types (Health and Social Care Information Centre, 2013). The majority of liver disease in the UK is the result of excessive alcohol consumption at a young age, and in some cases, may be associated with other causes of death, such as a stroke. However, the most immediate and significant risks associated with alcohol consumption include injuries and deaths from accidents. The European School Survey Project on Alcohol

and Other Drugs (ESPAD) reported that 13% of young people in the UK have individual problems including poor performance at school or work, damage to objects or clothing, loss of money or other valuable items, accident or injury, and admission to an emergency room due to alcohol abuse (Hibell *et al.*, 2004).

In 2007/2008 over 7,600 young people in England aged under 18 years old were admitted to hospitals due to intoxication from alcohol consumption. They also required emergency medical assistance. In 2006, 251 road users aged 16 to 19 years died within 12 hours of being injured in a road accident. It was discovered that 25% of the young people were reported to have blood alcohol levels above the legal limit for driving in England (80 mg/dl at that time) (Donaldson, 2009). Moreover, the ESPAD survey in 2007 (Hibell *et al.*, 2009) showed that young people aged 15 and 16 years old had engaged in unprotected sex (11% of boys and 12% of girls), 22% of boys and 14% of girls reported having a fight and 18% of boys and 13% of girls getting into trouble with the police. This was similar to a survey in 2008 that boys were more likely to have a fight than girls (Donaldson, 2009).

In addition to accidents and delinquent behaviour, Young people who consumed more alcohol in risky environments increased the risk of injuries and traumatic accidents. Zeigler *et al.* (2005) believed that the misuse of alcohol at a young age was associated with detrimental physical and mental problems. Children who first used alcohol before age 14 years were at increased risk of developing alcohol use disorders and other consequences of alcohol use, including blackouts, hangovers, and alcohol poisoning. The reasons revealed by the researchers for their findings are smaller body mass, patterns of drinking such as binge drinking, and their lack of experience with alcohol which reduces their tolerance to the substance. Binge drinking adversely affected children's study habits and eroded the development of transitional skills to adulthood.

### **2.7.2 Consequences of drinking among young people in Thailand**

The alcoholic consumption of young people in Thai has emerged as a serious public health concern during the past few decades. There is a significant increase in the

consumption of alcohol among young people aged between 11 and 19 years old (Thai National Statistical Office, 2007; 2011).

Many studies (e.g. Mulvihill *et al.*, 2005; Hibell *et al.*, 2004; Hibell *et al.*, 2009) have focused on the social, medical, legal and social consequences of drinking by youth. Binge drinkers are often involved in roadside accidents, costing the lives of themselves and others. Those who become crippled due to these accidents are unable to participate in economic activities. An association between the high occurrences of alcohol use and violent delinquency has been established (Eklund and Klinteberg, 2009). In addition to the medical and social consequences of alcohol misuse, the economic costs associated with alcoholism have been the focus of many researchers (French and Maclean, 2006; Hibell *et al.*, 2004).

According to Thavorncharoensap *et al.* (2010), alcohol consumption by Thai people has burdened the economy. The total economic cost was estimated by counting health care costs, productivity loss, property damage and law enforcement costs. It was estimated to be \$9,627 million (USD). That is nearly 2% of the total Gross Domestic Product (GDP) of Thailand.

Moreover, Assanangkornchai, Mukthong and Intanont (2009) undertook a survey of the health risks from alcohol consumption among high school students in Thailand in 2007 to 2008. Findings showed that students who are binge drinkers were associated with drinking consequences including driving a car or motorcycle after drinking, nausea and vomiting, and having a hangover more frequently than non-binge drinkers. Assanangkornchai *et al.* (2010) revealed that the three most common consequences for boys and girls aged 12-19 years were quite similar. The common consequences of boys include: fighting while drinking (26.1%), financial problems (19.1%), and feelings of guilt or remorse after drinking (18.6%). In the meantime, the commonest three consequences for girls were: feelings of guilt or remorse after drinking (17.5%), financial problems (19.1%), and problems with work, study or employment opportunities (9.8%). Furthermore, the national statistics showed that young people aged 15 to 19 years usually had aggressive behaviour, injuries, and sickness or a problem with work after drinking (Thai National Statistical Office, 2007).

As discussed in Section 2.7, the excessive alcohol consumption by young people has harmful consequences in terms of individual health, social benefits and violent behaviour. Violent behaviour, delinquency and patterns of alcohol consumption among young people are significant. In Britain, young people have suffered different medical consequences and it has caused the most accidents. The impact of alcohol consumption on the Thai economy has been described in this section. This strongly supports my idea to conduct research, which aims to protect young people's health from the harmful consequences of alcohol use. Moreover, the consequences of alcohol consumption from the literature review is one of the elements used to develop one part of my questionnaire. The fifth part of the questionnaire asks young people about the consequences of drinking alcohol. The question is 'In the past year, as a result of drinking alcohol have you ...?', and then choices are provided for selection such as 'had an argument', 'had a fight', 'violent event', 'assaulted'. The detail of this part can be seen in Section 4.4, Chapter Four.

The issues arising from alcohol consumption by the young people and its varied consequences are closely connected to aspects related to the places where people drink – and, implicitly, the availability of alcohol products for the youth – and the reasons leading to such behaviour. The following section provides information of location of drinking, drinking motives, factors influencing young people's drinking, prevention strategies, Buddhism and alcohol use, and Alcohol policy which relates to young people's alcohol consumption and is relevant to my research in the establishing of recommendations for reducing alcohol consumption.

## **2.8 The Location for young people to drink and drinking motives**

### **2.8.1 Location of drinking**

Young people prefer to drink in a variety of places (Henderson *et al.*, 2013). The selection of where to drink is largely influenced by factors such as ethnicity, family background and culture. According to the SALSUS (Black *et al.*, 2008; Black *et al.*, 2010), there was a difference consumption location between young people aged 13 and 15 years. In 2008 the 13-year- old students were more likely to consume alcohol

at home (52%) followed by drinking outdoors (33%) and at someone else's home (32%). In contrast, fifteen-year-olds usually drank at someone else's home (51%) following by at a party (49%), and outdoors (43%). This situation is similar to the findings in 2010. Thirteen-year-old students usually drank at home (52%), at someone else's home (31%), and outdoors (27%). Fifteen-year-olds reported that they drank at someone else's home (52%), at a party (52%) or outdoors (36%).

Another study carried out by the Health and Social Care Information Centre (2012) showed that students usually consumed alcohol at their homes (49%), following by at parties with friends (44%), at someone else's home (43%) or on the street, in a park or somewhere else outside (25%). This trend was different for older students who usually drank anywhere else apart from home.

Henderson *et al.* (2013) who studied young people aged 11 to 15 years from 7,589 pupils in 254 schools throughout England found that younger students usually drank alcohol in their own home more than older students (64% of 11 to 12-year-olds, compared with 48% of 15-year-olds). Students aged 15 years usually consumed alcohol at someone else's house (55%, compared with 28% of 11 to 12-year-olds), at parties with friends (62% and 16% respectively), or outside (20% and 8% respectively).

Regarding young people's alcohol consumption in Thailand, young people aged 12 to 19 were more likely to drink alcohol at a friend's or relative's house (47.7% of boys and 39.6% of girls) or in their own home (26.7% of boys and 30.2% of girls) followed by at a party (8.2% of boys and 15% of girls). Drinking in a pub, bar or restaurant was not popular for this age group (7.5% of boys and 3.8% of girls) (Assanangkornchai *et al.*, 2010).

In summary, the most common place for younger students to consume alcohol is in their own home. This trend is different from older students who usually consume alcohol at someone else's home. Drinking in pubs or bars is not popular for young people aged 12 to 19.

## 2.8.2 Drinking motives

Studies on drinking motives have explored whether a person decides consciously or unconsciously to consume or not to consume any alcoholic beverages, according to the expectation about whether the consequences of drinking will be positive or not. Cox and Klinger (1988) indicated that various factors (e.g., past experiences with drinking, current life situation) help people to form expectations of affective change from drinking.

Plant and Plant (2001) pointed out that the reason that young people consume alcohol is because adolescents get pleasure from alcoholic beverages' taste and effects. Individuals normally consume alcohol because they enjoy it and get refreshment from the effects of alcoholic beverages. However, situation-specific factors affects young people's drinking behaviour and thus they might drink in a different way in different situations. For instance, when young people were with their family, they might have a sip of alcoholic beverage, but they might drink heavily during a party or with their peers, or before watching a football match. They might also drink heavily during study/exam periods. Moreover, peer pressure and curiosity is one factor that leads young people to consume alcohol (Plant and Plant, 2001).

Kuntsche *et al.* (2005) reviewed the evidence of young people and young adults and their drinking motives through a computer-assisted search of relevant articles. The findings revealed that most young people age group of 10 to 25 year olds indicated that drinking was due to social motives; some of them reported that they drank for enhancement motives and only a few of them described drinking for coping motives. In general, most young people drink for a social reason or for a sense of enjoyment. Among 14 to 16 years in the UK, they drink in order to make a party more enjoyable (Kuntsche *et al.*, 2005). A year later Kuntsche *et al.* (2006) reviewed the empirical research of young people aged from 10 to 25 years old who had specific motives for drinking. Their paper revealed and discussed three factors that claim to be motives behind drinking in young people (Kuntsche *et al.*, 2006). The first was socio-demographic factors including age, sex, and trends over time. The second was

personality-type such as sensation-seeking, low inhibitory control, sociability, and anxiety sensitivity. Finally, contextual factors included culture and drinking situations.

Ahlström and Österberg, (2005) reviewed and pointed out two main factors that affect young people's drinking behaviour, namely internal factors and external factors. Internal factors referred to characteristics such as gender, personality factors, and biological traits. Age and gender were significant issues influencing drinking behaviour. During youth, girls might drink more often than boys since they tend to mature faster than boys and do not have family and responsibilities. However, when they reached young adulthood, young males tended to drink more alcohol and more often than young females. Concerning external factors referred to social norms or culture, physical availability, and price of alcohol: for social norms, the most reliable predictor for young people drinking is their friends' drinking behaviour and siblings' drinking. Moreover, the parent-child relationship, communication and practices also influence young people's alcohol consumption. Culture influenced how much teenagers drink. For instance, adolescents were more likely to drink alcohol more frequently in Mediterranean cultures than adolescents in other regions (International Center for Alcohol Policies, 2014).

Another factor is alcohol availability and pricing. In most European countries, the Minimum Legal Drinking Age (MLDA) is 18 years, but several countries such as the USA and Indonesia do not allow young people to consume, sell, or buy alcohol before the age of 21. High alcohol tax is an effective policy for controlling alcohol consumption among young people as well as strict regulation of the sale of alcohol with limits of locations and times (Ahlström and Österberg, 2005). Higher taxes on alcoholic beverages are more successful in terms of decreasing young people's drinking than execution of a minimum legal drinking age (Ahlström and Österberg, 2005).

This section aimed to explore the important variables for the purposes of this study, namely the places where drinking occurs, and, closely connected to this issue, the reasons behind alcohol consumption. The analysed literature studies and the use of methods from literature review to questionnaire, psycho-sociological test or



interviews, has shown that there are many places chosen by young people for alcohol consumption (in their peers' places, but also in public spaces), and these are influenced by factors such as ethnicity, culture and family background.

These factors are closely connected to the consequences of alcohol consumption by young people as, on the one hand, they may account for the availability of alcohol and the factors facilitating drinking, and they inform understanding of young people's drinking behaviour and may contribute to designing mitigation strategies. Similarly to section 2.7, this section has served as a framework for analysis, as it provides a model to investigate the factors that facilitate alcohol consumption and the preferred places of drinking.

## **2.9 Factors influencing young people's alcohol consumption behaviour**

This section reviews different factors that influence young people's behaviour. The key influencing factors include: family, peers, friends, school environment, and media or advertisements. These factors reveal the main reasons for young people engagement in drinking, as the environment has a strong influence on the behaviour of teenagers. Identifying the cause of the problem can generate the appropriate identification of suggestions to protect young people from the negative effects of drinking.

### **2.9.1 Family roles and young people's drinking**

Family forms the immediate environment for an individual. It influences the development and behaviour of individuals towards the use of substances. SALSUS (Black *et al.*, 2010) reported that young people (aged 15) in Scotland were willing to tell their family about their substance use. On the other hand, this trend was low among the young people aged 13. The behaviour of peers, parents and family members towards smoking, alcohol use and other substances highly affects young people's decisions regarding substance use and abuse. If young people thought that their families would disapprove of their drinking habits, they did not tell them (Dishion and Kavanagh, 2000).

Vantamay (2009) conducted a cross-sectional survey of 1,200 students in six universities about alcohol consumption among university students aged 18-24 years in Bangkok, Thailand. The researcher found that adolescents are sometimes likely to ask their parents or peers for information regarding health and alcohol use. Here the students see how parents can act as sources of information and models for educating their children with regards to the use of alcohol. However the parents' advice and education will of course depend on their own attitudes towards alcohol consumption. Assanangkornchai *et al.* (2002) and Chaveepojnkamjorn and Pichainarong (2007) found that Thai parents do not often provide the best education or advice surrounding alcohol use. Parents do not often act as good role models for their children, and often are the root cause of their children's drinking patterns (Assanangkornchai *et al.*, 2002; Chaveepojnkamjorn and Pichainarong, 2007).

Assanangkornchai *et al.* (2002) researched the effects of paternal drinking, conduct disorder and childhood home environment on the development of alcohol use disorders in the Thai population (n=312 aged 18 and over). The findings showed that there was a significant relationship between having a father who enjoyed drinking and the occurrence of drinking-related problems in children. It was more likely that if fathers consumed lots of alcohol, then their children would do the same. Moreover, Mulvihill *et al.* (2005) explored spirituality in families and its role in the prevention of drug abuse among adolescents, and concluded that the belief and behaviour of parents and other family members shaped the behaviour of young people.

Several research studies show that the attitude of parents regarding alcoholic beverage influence young people drinking habits (e.g. Sieving *et al.*, 2000; Van Der Vorst *et al.*, 2006) through parents demonstrating approval of drinking, and offering access to alcoholic beverage (Brown *et al.*, 2008; Donovan, 2004). Family factors such as family structure, social control, and negative life occurrences were strongly connected to intense alcohol use among young people (Kask, Markina and Podana, 2013). According to social control theory, it is one of the most significant concepts regarding the family's role. Kask, Markina and Podana (2013) pointed out that young people who are close to their family would be influenced regarding family values which affect the child's behaviour. A study by Thomas *et al.* (2000) supported this research: young

people who came from families monitoring the children's drinking could decrease young people's alcohol use. Another research finding showed that when family members knew where young people spent the night, young people would drink less than when the family had no idea where their children were (Ledoux *et al.*, 2002).

On the other hand, Kumpfer (1998) noted that young people who came from high stress families and dysfunctional families, had a big risk of alcohol problems. Young people who defined their family as somewhat authoritative tended to drink less than young people who described their family as neglectful parents (Adalbjarnardottir and Hafsteinsson, 2001). Furthermore, the young people who came from a single-parent family were more intense alcohol users than those who had both a mother and father in the family (Kask, Markina and Podana, 2013).

Family bonding provides strength to the relationship between children and their parents. Ideally, young people should abide by the norms and culture of the family, and obey their parents on grounds of the hierarchy of the family structure (Jones *et al.*, 2006). At this age, the impact of the family is most prominent as, according to the model proposed by Erikson (Crain, 2011), young people are at the time when they are faced with the 'psycho-social crisis', trying to find their identity. The appeal role-models is very important at this point, and it is likely to shape the young people's attitude towards drinking.

Kumpfer and Alvarado (2003) suggested that adolescence is a period of great stress and anxiety for both the young person and their families. Additionally, other researchers argue that young people passing through adolescence may exhibit non-social, unethical behaviour during this phase in life (Berk, 2013), for instance, deviant behaviour may involve drinking, violent activities with friends, theft, sexual assaults, rash driving and substance abuse. Velleman (2009) argues that these types of behaviour may be reduced by means of family influence, which accounts for the important role that parents play. The chapters dedicated to the analysis of the survey questionnaires (Chapter Five) and to the participatory action research (Chapter Seven) will further identify youth drinking behaviour as well as the place occupied by the family within the Thai culture.

Furthermore, a study carried out by Kumpfer and Alvarado (2003) exploring the impact of the family on young people's attitude towards drinking has revealed that parents are the most influential factors in alcohol and drug prevention and healthcare interventions. Discussing in detail the implications of binge drinking across the UK population, together with the possible ways to mitigate its negative consequences, several studies (Kumpfer and Alvarado, 2003; Ary *et al.*, 1999; Center for Substance Abuse Prevention, 2000) have shown that the role of parents can be further strengthened by skill training, communication development, parental monitoring and parental involvement in prevention programs. The effectiveness of the family structure, family members and parents play a part in shaping the young people's development into adulthood.

### **2.9.2 Peer pressure**

Peer pressure is a major cause of young people initiating substance use and negative behaviour (Johnson, O'Malley, and Bachman, 2001). Williams, Davies and Wright (2010) who conducted research investigating young people age 9-17 years and alcohol use suggested that peer pressure was the most common cause of young people in general drinking alcohol (54%). Peer influence and friends constitute significant elements on which peer intervention programs are focused. The emphasis of these interventions is on the way that peers interact, e.g. as educators or as supporters. Peer pressure has been identified as a significant factor in intervention and prevention programs (Webster, Hunter and Keats, 2002; Valente *et al.*, 2007). Peer education refers to the perspective that young people of the same age, gender and interests can engage others in some activities. It leads them to healthy life styles. This is especially the case for drug or alcohol abuse, explored in detail in several studies on the impact of peers and family on young people's attitude towards drinking, as well as the way in which teens enter into contact with alcohol products through media and advertising (Velleman, 2009; McDonald *et al.*, 2001).

Most peer education programs are included in school level interventions. The study of Cole, Cole and Lightfoot (2005) draws on Erikson's identity versus role confusion stage, and points to the positive influences that young people are likely to have on each

other. As Cole, Cole and Lightfoot (2005) posit, adolescence is the stage when teens begin developing their identity within the social groups that they belong to, which contributes to changes in their attitude or behaviour towards certain things, and even changes in their care for their peers (friends and colleagues at school). However, young people must be provided with the necessary skills to transfer knowledge and communicate with peers. Peers are significant for altering the behaviour of young people: because they are in the same age group, young people feel free to communicate and discuss with their peers because they are in the same age group (Velleman, 2009).

Young people are reported to believe that their peers are in a better position than adults to understand their perspective and problems. Moreover, young people also think that adults are distanced from 'their world' and problems (Webster, Hunter and Keats, 2002), so peers help by gaining an understanding of the perspectives of young people.

### **2.9.3 School context**

Considering the fact that the survey I carried out was directed at school students and that it was conducted within the school environment, it is necessary at this point to discuss the school context and its influence upon the students' behaviour and attitudes.

The school context includes the environment, sports, extracurricular activities, peer groups, interaction between teachers and students and the participation of students in decision-making at school. School environments impact the cognition and behavioural responses of students. They enable them to develop a positive personality. Schools that maintain a healthy environment<sup>4</sup> and a higher participation of students in decision-making have less behavioural issues (Valente *et al.*, 2007; Shears, Edwards and Stanley, 2005).

Moreover, Velleman (2009) said that school-based environments have been reported to have positive and negative impacts on young people's behaviour, in and outside school settings. The emerging literature also suggests that lasting cures of the misuse of substances are due to school-based skill development and awareness programs. For

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<sup>4</sup>According to the World Health Organization, a school that promotes a healthy environment is "one that constantly strengthens its capacity as a healthy setting for living, learning and working." (WHO, 2004: p.2).

example, sufficient empirical evidence is available showing the effective role of the school environment in the significant reduction of smoking (Velleman, 2009). Similarly, one research study of the effect of classroom environment on marijuana use; Araos *et al.* (2014) noted that a classroom environment can discourage marijuana use among Chilean students. The study found that students belonging to classes with a higher level of school bonding<sup>5</sup> showed lower proportions of consuming marijuana than students who were with a lower school bonding average.

Another study by Fletcher, Bonell and Hargreaves (2008) systematically reviewed many studies about school environment and young people's behaviour. They found that the school social environment was associated with drug use behaviour. In this case, they also reported the association between disengagement and poor teacher-student relationships and drug use and other risky health behaviour. Moreover, they also commented that positive relationships between students and school staff, particularly teachers, are very important in creating a healthy school environment and that this may be particularly crucial to foster students' resiliency regarding substance use. Furthermore, one study commented that using drugs was a result of trying to escape anxieties about school and was a source of self-medication in response to exam stress or a constant sense of academic failure (Fletcher *et al.*, 2009). Students who used alcohol in middle school were predictive of becoming binge drinkers during high school (Guilamo-Ramos *et al.*, 2005).

#### **2.9.4 Media and advertisement**

Smith, Cowie and Blades (2011) argue that media and advertisements are among the key factors that influence the way that young people become aware of, acquire attitudes to and develop intentions and expectations concerning the use or misuse of substances. The effects of media are very hard to tackle, as intervention programs for abolishing the negative impacts of media campaigns and advertisements is both time consuming and costly. In Thailand the importance of tourism for the economy of the country influences the extent to which media and advertisements are targeted by

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<sup>5</sup>a higher level of commitment to their school and their teachers

government policies. Therefore, although an issue for Thailand as well, media and advertisements for alcohol are not confronted with significant restrictions, with special rules for alcohol that comes from outside Thailand (Alcohol Beverage Control Act, 2008).

Ellickson *et al.* (2005), Hornik *et al.* (2008) and Mackey, Liang and Strathdee (2013) have explored the significance of media to alter adolescents' behaviour in respect of substance abuse. This is similar to Velleman (2009), Grube and Waiters (2005), Winpenny *et al.* (2012), and Winpenny, Marteau and Nolte (2014) who have explored how media and advertisements are major impacts on young people's attitudes and behaviour towards alcohol from the media (film, music, magazines, social network), advertising and marketing.

A study conducted by Ellickson *et al.* (2005) has demonstrated that exposing the 7<sup>th</sup> grade (non-drinker) adolescent to beer advertisements in the media or in stores, may result in an onset of drinking until 9<sup>th</sup> grade. Similarly, the same study revealed that the exposure to discount stands of beer in sports grounds and public places, would stimulate a drinker in the 7<sup>th</sup> grade to increase the frequency of drinking (Ellickson *et al.*, 2005). Additionally, a review of longitudinal studies conducted by Anderson *et al.* (2009) concluded that advertisements and promotions of alcohol products are likely to increase the possibility that young people start drinking, or even consume more alcohol if they have already started drinking.

The literature on drinking across the younger generation has pointed towards the key aspects involved in youth alcohol consumption, such as the impact of the family or peer pressure. However, as broad as the investigated literature may be, such a survey seemed insufficient to explore in more detail the social factors associated with alcohol use in young people. Therefore, the analysis of the available literature called for more in-depth investigations; in order to do this, I complemented these findings with participatory action research, which involved focus groups and in-depth interviews with the stakeholders.

## **2.10 Prevention strategies to reduce alcohol consumption by young people**

The misuse of alcohol by young people has increased continuously over the last decade (Advisory Council on the Misuse of Drugs, 2006). Gill (2002) also reported an excessive use of alcohol by male and female students, having reviewed more than 25 years of literature about alcohol consumption among adolescents. The report concluded that significant numbers of both male and female students are reported to exceed sensible weekly consumption guidelines, and the recorded levels of binge drinking among both genders are extremely variable between studies. The report also recommended that those needed for further research to clarify this position. In this report the harmful drinking for the health and well-being of students are reviewed. A possible link between poor academic performance and alcohol consumption appears tenuous and merits further investigation. Evidence relevant to the view that the drinking behaviour of female students is changing is considered. Therefore, the misuse of alcohol is a major family, organisational, social and policy concern. The following section will present the programmes to prevent young people from drinking. Several programmes have been introduced and implemented for the prevention of alcohol intake by young people. Thus, this section reviews and summarises the effectiveness of prevention strategies for alcohol consumption by young people.

### **2.10.1 Prevention strategies at Policy Level**

At policy level, prevention strategies include age restrictions on the availability and purchase of alcohol in different places. For some countries, it is illegal for young people under 18 years of age to purchase alcohol for their own use (ICAP, 2013). Lawmakers have implemented policy strategies that focused on: reducing alcohol availability for young people, restricting commercial access, regulating the content of alcohol advertisements and its exposure to young people, reducing economic and social access and raising the Minimum Legal Drinking Age (MLDA). Moreover, laws about blood alcohol concentration limits and drinking and driving have been developed to ensure that the risk for harm is minimised for young people who drink (ICAP, 2013).



The literature shows that policy level strategies have proved ineffective. The results of a survey by Harrington carried out between 1998 and 1999, revealed that more than 60% of young people aged 16-17 years old, and 10% of young people aged between 12 and 15 years old, purchased alcohol (Harrington, 2000). Retailers refused only one-third of under-18s. Bars, pubs and nightclubs were identified as popular outlets where under-18s tried to buy alcohol (Harrington, 2000).

In 2010, the SALSUS reported that 12% of young people aged 13 compared with 22% of those aged 15 illegally purchased alcohol from shops. 1% of young people aged 13 and 2-3% of young people aged 15 bought alcohol from pubs, bars or clubs (Black *et al.*, 2010). This trend had declined in 2013: the findings of the SALSUS showed that few young people purchased alcohol from pubs, clubs, shops or supermarkets (Dodds *et al.*, 2014).

Cuijpers (2005) and Foxcroft *et al.* (2003) have questioned the effectiveness and implementation of policy level strategies. They are of the view that the strategies have no impact on the use of alcohol by young adults because they address in the first place institutions and organisations, with policies that do not reach the core issues that make young people consume alcohol. Policies are aimed at helping these structures find solutions for young people, so that they tackle the issue from a sociological point of view.

### **2.10.2 Prevention strategies at Family Level**

Parents are the most important people who have an influence on young people's attitudes towards alcohol (Kask, Markina and Podana, 2013; Donovan, 2004). Moreover, Sondhi and Turner (2011) stated that parents effectively succeed in conveying the social pleasures and risks of alcohol use at home. Young people also learn and copy messages and behaviour from parents or family members. However, young people are not taught to recognise the health consequences of drinking. Parents should apply this implications to talk to children about alcohol on learning to drink safely at home, other drinking practices and environments, and the consequences (Valentine *et al.*, 2010).

Furthermore, Bauman *et al.* (2001) who conducted a study on the effect of family-based intervention programmes, showed that the effects of the prevention programmes increases considerably when both parents participate in the intervention.

Family-level prevention strategies for drug and alcohol abuse are the most effective (Valleman, 2009). This implies that theories emphasising an ecological approach (See more details in Section 3.3) and the influence of peers and family members, about the behaviour of individuals, are empirically supported (Valleman, 2009). These findings have led me to the use of an ecological approach in my present research.

The review of literature suggests also that prevention programs of alcohol misuse, especially family-based interventions such as the Family-Strengthening Approaches (Kumpfer and Alvarado, 2003) showed long-term results. The family-strengthening approach is focused on developing and promoting activities, services and programs that are designed to consolidate the interpersonal relationships among the family members, with a focus on contributing to the healthy development of adolescents. Kumpfer, Alvarado, and Whiteside, (2003) reviewed family-level prevention strategies. These included: Family Therapy, Family Education, Behavioural Parental training, Family Skills training and In-home Family Support. They concluded that family-level interventions were two to nine times more effective than those solely focused on children. These included school-based, individual-based and peer-based strategies.

It has been suggested (Small, 2010) that the core components of Family Level prevention programs should be incorporated, and integrated, into other substance abuse prevention and intervention programs. The core attributes of family-level strategies include enhanced interaction, the ability to build resilience among young people towards substance abuse, and engaging families who are otherwise hard to reach.

### **2.10.3 Prevention strategies at School Level**

The main focus of these prevention strategies is on young people and the school environment. Thus, these strategies are directed towards curricular activities aimed at

educating young people regarding the negative effects of excessive alcohol consumption at a young age.

According to Jones *et al.* (2007), school-based interventions were the most commonly applied interventions. The Life Skills Training (LST) was a school-based prevention strategy. It has often been explored and evaluated by researchers. There were less, but positive results in minimising the indicators of alcohol or other drug abuse. Life Skills Training was created in the attempt to prevent the use of drugs, alcohol and tobacco among young people. The methods used involve developing social and self-management skills, as well as skills for resisting peer pressure. This represents an example of an approach that addresses the cause of the problem. Extracurricular activities and sports are also reported to reduce problems associated with alcohol abuse among adolescents. Jones *et al.* (2007) stated that school-based prevention strategies were most widely used to develop and implement universal drug prevention programs. This is similar to the National Institute for Health and Clinical Excellence (NICE, 2007) guidelines on interventions in schools to prevent and reduce alcohol use among young people.

Stothard and Ashton (2000) claimed that the LST was a competency development strategy. It focused entirely on key psychological and social factors that promoted substance abuse. Another study, carried out by Fletcher, Bonell and Hargreaves (2008) carried out a systematic review on the influence of a school's setting with regards to the misuse of drugs and substances by young people. The review showed that a supportive, inclusive, engaging and interactive culture at school, and extracurricular activities, were likely to have a positive impact on non-normative alcohol consumption, and disengagement and poor teacher-student relationships were associated with drug use and other risky health behaviour. Moreover, Cuijpers *et al.* (2002) claimed that the Healthy School and Drugs project as implemented in Holland may have some effect on drug use in the children exposed to it.

#### 2.10.4 Prevention strategies at Community Level

Community is a wider level compared to family and school levels. Strategies at community level engage the family, school settings, peer elements and other ecological factors, such as the intrapersonal, the interpersonal, or the organisational level, which all influence the behaviour of adolescents towards drug abuse. Stead *et al.* (2006) stated that some community-level strategies showed a smaller reduction in substance misuse. Examples of successful multi-component prevention strategies are: Project SMART (Standardising Measurement of Alcohol Related Troubles) funded by the European Union that aimed at developing a standardized comparative surveys methodology on drinking and all its facets as well as assessing the economic impact of existing alcohol policies in the EU (Hansen *et al.*, 1988). Project SMART focused on the personal skill development of 7th grade students in enhancing resistance towards alcohol and other drugs. It also trained students to resist peer pressure.

Other community intervention programmes had significant effects on the substance use. Biglan *et al.* (2000) studied a community programme that included media advocacy, youth anti-tobacco activities, family communications about tobacco use, and reduction of young people's access to tobacco and other substances. Project Northland (Stigler *et al.*, 2006) is an intervention project which included classroom curricula, peer leadership, extra-curricular activities, parent programs, and community activism in order to prevent and reduce alcohol use among students.

The Adolescent Transition Program (ATP) is another example of a community level strategy. It focused on parental training for effective communication with young people and early adolescents who were at risk of alcohol abuse. It was also a multi-faceted strategy involving school, family, parental group meetings and peers. Consequently, the next section will explore prevention strategies involving the peers, as an important element in the fight against alcohol consumption at a young age (Dishion and Kavanagh, 2003).

### 2.10.5 Prevention strategy using peers

Kok *et al.* (2008) have explored prevention strategies involving peer pressure to reduce the misuse of alcohol. These programs are aimed at developing the ability of young people to withstand peer pressure and show a resistance to drug use at an early age. Strategies for peer interventions, skills enhancement and programmes focused at individual levels, are also implemented to reduce drug abuse by young people in the UK. Furthermore, strategies involving peers are also included in the Life Skills Training programme, Project Northland and the Adolescent Transition Program.

In this section it can be stated that prevention strategies at the family-level are the most effective for achieving long-term behavioural change towards alcohol, and other substance abuse. Testing prevention strategy was one of the aims of the present study. Policy level strategies have not been effective due to the lack of implementation of regulations such as the Minimum Legal Drinking Age (MLDA). The present review suggests that school-level prevention strategies involving sports, and other extracurricular activities, reduced alcohol-related problems among young people. On the other hand, community-level prevention strategies show a positive influence on the misuse of alcohol. This information is very useful for supporting the findings from qualitative data analysis of appropriate prevention strategies for controlling alcohol consumption by young people.

As the above information shows, many researchers have studied prevention strategies to control alcohol consumption by young people. Within the Thai context, religion – more precisely, Buddhism – plays a significant role in shaping young people's attitudes and behaviour in relation to alcohol (Newman *et al.*, 2006). The next section will tackle the relationship between Buddhism and alcohol consumption, in order to gain a better understanding of the measures that can be taken to prevent young people from drinking.

## **2.11 Buddhism and alcohol consumption**

In this section, the relationship between Buddhism and alcohol consumption is reviewed and divided into three parts. The religious aspect is very important for this research as Thailand is a country where religion and culture play a very important role in people's lives. The percepts included in Buddhism regarding alcohol raise a challenging question about the way Thai people interpret and apply Buddhist principles and to what extent these principles influence the drinking behaviour of young people. Firstly, I discuss the history, roles and situation of Buddhism in Thailand. Secondly, I discuss the drinking culture in Thailand, and finally, religion and teenager's alcohol use.

### **2.11.1 The history of Buddhism and Buddhism in Thailand**

Buddhism has a long history dating back over 2,500 years. Currently, there are more than 487 million followers of Buddhism worldwide (Pew Research, 2012). According to the Pew Research (2012), most Buddhist populations are in the Asian-Pacific region. The top three countries that have the largest Buddhist populations are China (about 244 million), Thailand (about 64 million) and Japan (45 million). However, there are Buddhist followers in western countries such as the United Kingdom where there are more than 150,000 Buddhists (BBC news, 2009). There are many branches of Buddhism. Bovornkitti (2005) identifies two main groups of Thai Buddhists, which consist of '*Theravada*' and '*Hinayana*' Buddhism. 'The Law of Karma' is highlights the teaching of Hinayana Buddhism, which emphasises the individual consequences of a person's behaviour whether commendable or sinful. The essence of the Buddha's philosophy lies within the Four Noble Truths and includes The Eightfold Path of Enlightenment which leads individuals toward the end of suffering.

There are about 18,000 Buddhist temples and approximately 140,000 Buddhist monks in Thailand (Newman *et al.*, 2006). Buddhism emerged in Thailand when King Asoka of India sent a group of missionaries to the Indo-China Cape. The evidence shows that Nakhonpathom Province, a central province in Thailand, was the first place where Buddhism became established in Thailand. It included stone writings, the images and

Footprints of Buddha, and the great Pagoda itself that had the same style as in the town of Sanchi in India during the period of the great King Asoka (The World Buddhist University, 2002).

Several religious ceremonies have been assimilated into Thai culture and tradition. Buddhism plays an important role in Thailand as the place where Thai people come to practise following Buddha's teaching, and to relax themselves for peace and enlightenment. The temple is both a meeting ground for communities and a place of sacred worship. Buddhism in Thailand also impacts alcohol use. Here, common practice involves observing the Five Precepts, which involve refraining from consuming alcohol, and drugs, which are both thought to lead to carelessness. This refrainment from drink and drugs is mainly understood as total abstinence from alcohol and drugs. Alcohol however is still widely consumed within many celebrations and ceremonies. (Newman *et al.*, 2006)

Although Buddhist teachings have a direct influence within Thai society, the teachings are not compulsory and therefore many variations are found within individuals' levels of spirituality. Rapid social change is currently challenging spirituality within Thai families, especially with regards to Thai adolescents and health problems resulting from alcohol use.

### **2.11.2 Culture and alcohol use**

This section focuses on alcohol use among various different cultures and religions and aims to analyse how different ethnic and cultural norms may influence alcohol use in people's daily lives. This aspect is of particular interest to the present study, given the importance of culture in people's lives, and especially in the Thai community. Culture shapes individual development in all aspects of life, including their attitude towards alcohol consumption.

A case in point is given by Heath (2001), who argues that:

*Alcohol consumption is influenced by the role of alcohol in daily life, beliefs and values of drinking in the culture, drinking norms and expectations about drinking, and the relationship of drinking to*

*other aspects of the culture. (Heath, 2001 cited in Moolasart and Chirawatkul, 2012 p.796)*

Many people seem to accept alcohol use and are not concerned about possible negative effects in their communities. Many researchers have studied the relationship between culture and alcohol use.

Bergmark and Kuendig (2008) evaluated the relationship between alcohol consumption and people's positive expectations of what effect the alcohol would have on them. Data was retrieved from '*Gender, Alcohol and Culture - An International Study*' (GENACIS), a collaborative project that involved the use of the same questionnaire in all countries that participated in the project. Cross-country comparisons of positive expectancy reports were conducted. The study analysed data from various countries and cultures including Europe, North and South America, Asia and Africa. The study found that across all countries, men had more positive expectations surrounding the effect that they thought alcohol would have on them than did women. This study shows a more prominent gender difference rather than an obvious difference between cultures and/or countries. In addition to this gender difference, it was found that the expectations of men in the Czech Republic and Japan were about feeling more sociable and more ready to interact with others after consuming alcohol. Also, males both within the UK and in Uganda reported drinking more due to their expectations of alcohol allowing them to talk with more ease to their partners. Males within the Czech Republic, Costa Rica, Argentina and Spain also reported expectations of alcohol making sexual activity more pleasurable. Males with this expectation drink significantly more alcohol. Similar findings exist for women within different cultures and countries, again reporting expectations of being more socially open and interactive with others when drinking alcohol.

Room *et al.* (2012) explored drinking times across different countries and cultures. They illustrated how in many traditionally alcohol-consuming countries, drinking is largely associated with holidays, festivals and other special occasions. During the 19<sup>th</sup> century, alcohol would often be consumed within the workplace, however alcohol consumption in the workplace was removed in most English-speaking countries and drinking became restricted to after work and during the weekend. This drinking pattern



has since circulated throughout several other countries and societies; however, contrasting drinking patterns still exist between different cultures. Room *et al.* (2012) argue that ‘time of drinking’ does differ between cultures; however, it does appear that some norms do exist with regards to temporal drinking patterns among different cultures and parts of the world. Drinking generally tends to be more likely after 5 p.m. and on weekends. An important finding from this study is the culturally specific implications for drinking patterns. Although there may be patterns among drinking times, the impact of this timing on problems associated with alcohol consumption cannot be generalised across cultures (Room *et al.*, 2012).

The reasoning behind alcohol consumption also differs cross-culturally, for example in Western countries, drinking is very much associated with social life. In Northern Europe, which Room and Mäkelä (2000) described as a ‘dry area’, individuals’ alcohol consumption consisted of beer and spirits. The purpose of this alcohol consumption was simply to ‘get drunk’ in order to loosen control and allow new friendships and relationships to be made with ease. The Southern or Mediterranean areas defined by Room and Mäkelä (2000) as the ‘wet area’ consumed mainly wine which was most often drunk during daily meals. Here the reasoning behind alcohol consumption completely contrasts with Northern Europe; its purpose here is for nutritional and cooking purposes.

Bennett *et al.* (1998) investigated the different drinking practices among various countries to see how they varied. They argue that an understanding of the differences in alcohol consumption can allow policy makers to develop alcohol policies which are effective and unique for each different country or culture. Bennett *et al.* (1998) conducted a cross-cultural comparison of three countries which all have extremely different cultural and ethnic features, especially with regards to the use of alcohol in their daily living. The countries analysed consisted of Nigeria, Mexico, and India. The analysis found that a universal classification of ‘normal’ drinking does not exist between these three countries. Neither does a universal definition exist in relation to problem drinking or becoming dependent on alcohol among the three countries. Differences are also found within these countries when explored individually, with different drinking patterns existing within different ethnic minorities and cultures

within each country. For example, in India, although it is seen as a country with a relatively low level of alcohol consumption, major cultural and ethnic differences exist between the Northern and Southern areas of the country.

The function of alcohol use is extremely complex and diverse, especially with regards to different religions and community practices. Therefore, this is one of the reasons why this research used a survey and PAR. There is an extremely complex landscape of drinking practices due to the vast religious, ethnic and class differences found within each individual country and culture. Bennett *et al.* (1998) also highlight the complexity of drinking patterns and alcohol consumption among different cultures in terms of continuing social changes. Social change often leads to variations in drinking practices. For example, Mexican men who migrate to the USA will modify their drinking patterns to those that are considered 'normal' in America. They will become more frequent drinkers, as this is favoured in America and also because of feeling sad and displaced as a migrant and drinking to ease their feelings. However in Mexico, consuming high levels of alcohol on occasions and events is relatively common, so this high level of drinking will remain the same even after migrating to America. Here we can already see some extremely complex relationships between culture and alcohol consumption.

Ritson (2011) describes today's drinking culture in the UK as an 'alcohol nation'. He describes how youths within the UK are more likely to consume alcohol in comparison to any other youths in the world. In addition, the alcohol consumption among teenagers within the UK is over double than in the majority of other countries worldwide (Ritson, 2011). Many researchers believe that there are not enough clear boundaries nor authority figures for children, which leads to dangerous drinking habits within their social groups. Ritson (2011) acknowledges that within the UK, as adults are drinking more and more, this has a direct influence on their children drinking more, and it makes it easier for children to do so. In order for children to be protected against harmful drinking habits, it is therefore necessary for parents to become responsible and more aware of their own use of alcohol. Ritson (2011) describes how alcohol is readily available for young people. In recent decades alcohol has become relatively low in price and has become the main source of entertainment for young people during the

evening. Ritson (2011) also describes the negative effects that excessive drinking has on young people, including physical and psychological consequences. For example there is a strong correlation between depression and excessive alcohol consumption. It is important for young people to know that rather than alcohol being a solution to low mood, it is actually often the cause of low mood in the first place.

Allamani (2008) explored the relationship between alcohol consumption, gender and culture. Each society differs with regards to their opinions on alcohol consumption, and it is these opinions that affect different drinking patterns within these societies. Allamani (2008) considered the association between women and drinking practices among different cultures. He argues that viewing the relationship between gender and alcohol consumption, is one way of indicating the views of a particular society. It has been found that women with higher levels of education are actually more at risk of consuming high levels of alcohol. In addition, women who are in work and women who do not have children were also found to be at an elevated risk for significant alcohol consumption. It was also found to be more probable for women to discontinue their alcohol use in comparison to men. Allamani (2008) argues that perhaps women find it easier to quit their alcohol consumption, as it is not as predominant in terms of their social roles as it is with the male population. Additionally, it is thought that perhaps different genders are biologically predisposed to different drinking patterns and behaviour. For example women tend to cease drinking when they are pregnant and as new mothers (Allamani, 2008; Cismaru *et al.*, 2010).

Wilsnack *et al.* (2009) carried out an evaluation of multi-cultural drinking patterns, with special consideration for alcohol consumption in terms of gender and age. It was found that men consume more alcohol than women, but as previously mentioned, it was also found that lifetime abstention from consuming alcohol was reliably much more predominant in women. The gender differences found with regards to alcohol consumption were universal, although often the size of these differences varied. Men are heavier drinkers, and women abstain long-term from alcohol consumption. No cultural differences or social/historical variations were found to erase these gender differences. Wilsnack *et al.* (2009) argue that as fairly few universals exist with regards to social behaviour in humans, perhaps there are biological gender differences in

relation to alcohol consumption in men and women. However it is also likely that drinking patterns are modified by cultural as well as biological influences.

With regards to Thai culture, there are relatively few studies that explore alcohol consumption. This accounts for the importance and necessity of the present research, which draws on similar studies carried out in different cultures (for instance, the UK) in order to provide a valid framework for the analysis of the young Thais' attitudes towards drinking. In general, it is understood among Thai people that drinking alcohol is a common occurrence (Assanangkornchai, 2006). It is common for Thai people to consume alcohol as part of celebrations and holy rituals. It is also the case that they will often offer alcohol to holy images. This is why alcohol is often consumed after religious ceremonies. Consequently, in the Thai culture, alcohol consumption is perceived as very positive and is deeply embedded in the community and religion. Due to the positive perception of alcohol within the Thai culture, adolescents often form drinking patterns from a relatively early age (Newman *et al.*, 2006; Moolasart and Chirawatkul, 2012).

Assanangkornchai *et al.* (2010) point out that their research revealed that people in Thailand were more open-minded when males consumed alcohol while it seemed more restricted for females. Nevertheless, this pattern has changed since there are now more Thai women who drink increasing volumes of alcohol (Assanangkornchai *et al.*, 2010). As I have described already, in Thai culture alcoholic beverages are a part of everyday celebrations including religious rituals. Thai citizens usually provide alcoholic beverages to holy images such as Shiva. When the ceremonies end, they usually drink those alcohol beverages because they believe that they are blessed drinks and they will receive the best wishes from holy images. Thus, alcohol use is considered as positive by Thai people, and young Thai children are often encouraged to engage in early alcohol use.

Moolasart and Chirawatkul (2012) studied drinking culture in the northeast region of Thailand known as *Thai-Isaan*. The findings showed that alcohol consumption was interwoven into everyday life for *Thai-Isaan* people. Drinking was included in several events such as drinking traditions, drinking in social activities, and drinking on special

occasions. It becomes clear that many people in Thailand have positive attitudes toward alcohol use. An example of drinking during a special local occasions is *Su khwan* a ceremony that means to recall a spirit or soul to the body. *Su khwan* is a kindly welcome or congratulation at a time of good luck or achievement. It included a tray of food and alcoholic drink. The ceremony usually ends with all guests and hosts sharing food and alcoholic drink together. Moreover, when people had house warming ceremonies, the host usually invited a number of monks in order to encourage good fortune and wealth.

In summary this section has tackled the importance of culture in shaping the individual behaviour in several aspects of life, including the attitude to alcohol consumption.

### **2.11.3 Religion and young people's alcohol use**

In Thailand, men in general who are Buddhists serve as Buddhist monks in the temple for at least a few days, weeks or months. Buddhism educates its followers with the Five Precepts (see Table 2.1), to which Buddhists are expected to conform. The fifth precept refers to refraining from alcohol consumption. Most people interpret it as the total abstinence from alcoholic beverage and illegal drugs however a few scholars claimed that it meant avoiding extreme consumption. Moreover, the Thai government promotes an alcohol policy called 'No Alcohol campaign' during the specific period of time (Moolasart and Chirawatkul, 2012; Newman *et al.*, 2006). For instance, during Buddhist Lent Day<sup>6</sup> in Thailand, there was a campaign called 'No alcohol use during Buddhist Lent period' which had support from the Thai government. This campaign aimed to decrease alcohol consumption for Thai people during this period (about three months). The Siam Technology College undertook an Internet Poll on alcohol use during the Buddhist Lent period. The result showed that 34.7% intended to stop drinking during the Buddhist Lent period while about 30% decreased their alcohol use (ASTV manager online, 2013). According to the study from Moolasart and Chirawatkul (2012), findings showed that alcohol use was related to the number of religious-related events. However, drinking was considered to be a fundamental part

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<sup>6</sup>Buddhist Lent is a period of three lunar months during the rainy season when monks are required to remain in one particular place or pagoda

of the social celebration on these events, not of the Buddhist activity. Listed below are the Five Percepts of Buddhism which represent the basic Buddhist moral and ethical code.

<b>Table 2.1 The Five Precepts</b>	
<b>Pali</b>	<b>English</b>
Precept 1: Pāṇātipātāveramaṇī, sikkhāpadaṃsamādiyāmi.	Precept 1: undertaking to observe the precept to abstain from killing living beings.
Precept 2: Adinnādānāveramaṇī, sikkhāpadaṃsamādiyāmi.	Precept 2: undertaking to observe the precept to abstain from taking what is not given.
Precept 3: Kāmesumicchācārāveramaṇī, sikkhāpadaṃsamādiyāmi.	Precept 3: undertaking to observe the precept to abstain from sexual misconduct.
Precept 4: Musāvādāveramaṇī, sikkhāpadaṃsamādiyāmi.	Precept 4: undertaking to observe the precept to abstain from false speech.
Precept 5: Surāmerayamajjapamādaṭṭhānā, sikkhāpadaṃsamādiyāmi	Precept 5: undertaking to observe the precept to abstain from intoxicating drinks and drugs causing heedlessness.

Source: Dahlke *et al.* (2008)

There exist many customs and ceremonies for Buddhist celebrations. Newman *et al.* (2006) explored Buddhism and alcohol use among adolescents in Thailand. It was found that practising Buddhists have a lower tendency to consume alcohol compared to non-practising Buddhists. In terms of students who consume alcohol, their Buddhist beliefs and practices did not seem to influence their drinking patterns or whether or not they engaged in binge drinking. Newman *et al.* (2006) concluded that Buddhist beliefs may have the potential to influence choices on whether or not to consume alcohol, but that these beliefs do not extend to choices in relation to specific patterns of drinking. However it became clear through these students that the religious practices influence their alcohol consumption and also what expectations they have surrounding the use of alcohol. Students who are active and committed Buddhists foresee a higher number of negative impacts from alcohol consumption than positive ones, in comparison to those who are non-practising (Newman *et al.*, 2006). In addition,

students would drink less if they had negative views of drinking regardless of whether they were religious practising or non-practising. Students who practised following the Buddhist beliefs consumed alcohol less than students who did not practise the Buddhist activities (Newman *et al.*, 2006).

It becomes clear that a relationship exists between religious practices and alcohol consumption and consequently, differing outlooks regarding alcohol exist among different religions and cultures. Burris, Sauer and Carlson (2011) suggest how religious practices can apply a protective effect against underage alcohol consumption. It was also found that religious commitment functioned as a protecting influence, although spiritual transcendence actually worked in the opposite way and acted as a risk factor for alcohol consumption. This highlights the importance of studying religious communities with regards to alcohol consumption.

Chamrathirong *et al.* (2010) highlighted the impact of parental spiritual and religious beliefs and how this will lead to impact their children's spirituality. The findings revealed that the spirituality of parents and teenagers within the family can have a preventative effect on adolescent health risk behaviour. The family's spirituality is an important factor in terms of decreasing health risk behaviour of youths in Thailand. In addition, Assanangkornchai *et al.* (2002) claimed that there was no association between early Buddhist upbringing and subsequent alcohol use disorders in Thai men, and that individuals who were strongly religious were less likely to be harmful drinkers or dependent on alcohol. Moreover, Merrill, Folsom and Christopherson (2005) explored the influence of family religiosity on adolescent substance use, and found that the highest substance use existed among individuals with no religious preference. Similarly Mason and Windle (2001) indicated that religion acts as a significant mediator between family, social support and adolescents' substance use.

Culture certainly influences alcohol use in young people's daily lives, and it also relates to religious practice. Many researchers state that culture is a prominent and noticeable correlate of alcohol use. People are aware that drinking practices in different parts of the world contrast massively and drinking practices even vary between different ethnic groups within one individual country. Differences exist in alcohol use

and misuse, and surrounding the type of alcohol consumed, the amount of alcohol consumed and the occasions/circumstances in which alcohol is consumed. Many drinking patterns exist all over the world. Furthermore, alcohol is embedded within religious activities. Many studies suggest that religious practice is a preventative method for adolescents against underage alcohol consumption. Adolescents who practise Buddhist preference have a lower tendency to consume alcohol compared to non-practising Buddhists. The Buddhist practice in the temple is a strategy to perform young people for good behaviour.

This literature review is very useful for the present study, which applies the Buddhist practice into a proposed intervention programme for secondary students in order to reduce the drinking problems. The proposed intervention programme will be discussed in Chapter Nine.

## **2.12 Alcohol policy**

According to the World Health Organization (WHO), approximately 2.5 million deaths each year are caused by the harmful use of alcohol (WHO, 2011). WHO states that:

*Alcohol consumption and problems related to alcohol vary widely around the world, but the burden of disease and death remains significant in most countries. Alcohol consumption is the world's third largest risk factor for disease and disability; in middle-income countries, it is the greatest risk. (WHO, 2011 p. X)*

Moreover, alcohol is an important factor in 60 types of disease and injuries, and almost 4% of all deaths worldwide are attributed to alcohol. Alcohol also related to numerous serious social issues, including violence, child neglect and abuse, and absenteeism in the workplace (WHO, 2011).

The WHO aims to reduce the health problems which caused by the harmful of alcohol consumption. Moreover, it needs to save lives, reduce disease and prevent injuries from alcohol use. In this case, the 'Alcohol Policy' has been developed as an organized set of values, principles and objectives to reduce the harmful burden of alcohol in a



population. It explains the global alcohol policy and hopes that this useful data will help to decrease global problems associated with alcohol use.

WHO defines “Alcohol policy” as:

*A collective noun, refers to the set of measures in a jurisdiction or society aimed at minimizing the health and social harms from alcohol consumption. These measures may be in any governmental or societal sector, and may include measures, which are not directly aimed at alcohol consumption; for instance, the promotion of alternatives to drinking, where such a measure has the aim of minimizing alcohol-related harms. A national alcohol policy will be made up of a set of individual policies, strategies, and implementing actions. There are also a variety of other policies which impinge on alcohol-related problems, increasing or reducing them, but which are neither normally described as alcohol policies nor normally included within an overall alcohol policy, since the policies are not adopted or implemented with the minimization of alcohol problems as a primary aim. (WHO, 2011 p. 40)*

The important other policies include such policies as ‘Availability of alcohol’, which is one of the most effective policies, restricting sales and consumption by people below a legal drinking age; ‘Prices and taxes’ is an effective strategy for reducing alcohol consumption by increasing alcohol prices, usually accomplished by raising alcohol taxes; ‘Drinking and driving’ is one of the most effective policies whereby maximum blood alcohol concentrations for drivers are set and then enforced through checkpoints and random breath testing, which can reduce the risk of traffic accidents; ‘Alcohol advertising and marketing’ is a policy to control alcohol advertising and marketing where the primary responsibility for regulating alcohol marketing lies within the alcoholic beverage industry itself (WHO, 2011; Anderson, Moller and Galea, 2012; WHO Regional Office for Europe, 2013; Suriyawongpaisal, Plitapolkarnpim, and Tawonwanchai, 2002).

#### *Alcohol policy in Thailand*

The alcohol policy in Thailand has been recently introduced there. The Thai Cabinet issued the Thai Health Promotion Foundation Act in 2001. An important task was the Alcohol Consumption Control Program. This aimed to decrease alcohol use and alcohol-problems related particularly to adolescents. There are three main strategies of

the program: the ‘creation of knowledge’, ‘supporting a social movement’, and ‘mobilizing political action’.

The Alcohol Beverage Control Act was set up in 2003 under the Ministry of Public Health, and then it was passed by Parliament in 2007 (Institute of Alcohol Study, 2007) which also passed further legislation in 2008. This was the Alcohol Beverage Control Act B.E. 2551 (2008) containing 45 sections. There are many sections of importance for reducing alcohol consumption by young people. For instance, Section 27 covers drinking location, with many public locations to be alcohol free zones such as educational institutes, public health service places, temples or places for performing religious ceremonies etc. Section 31 states that people cannot drink alcoholic beverages in these places. Section 29 stipulates the minimum age of purchasing alcohol as 20 years old. Another section, which is very important, is Section 32 which states that “people cannot advertise or display names or trademarks of alcoholic beverage deemed to exaggerate their qualifications or induce people to drink such alcoholic beverage either directly or indirectly” (The National Alcohol Control Committee, 2013; Alcohol Beverage Control Act., 2008).

This section has outlined how alcohol policy aims to reduce alcohol consumption by young people in many countries around the world. The WHO has been concerned about this problem, which relates to cause of death and disability, and it is also associated with social problems and economic problems. Thus, WHO has developed the Global Strategy to Reduce the Harmful Use of Alcohol (WHO, 2010). In Thailand, the alcohol policy has been formulated in line with the WHO’s policies aiming to reduce alcohol use and to raise awareness of the importance of the health, social and economic problems caused by the alcohol use, and to increase government commitment to address this. Referring to my study, alcohol policy is one of the aspects which affect young people drinking which will be explored through the qualitative findings presented in Chapter Seven.

## **2.13 Strength and limitation of the studies**

The studies which I analysed offered a wide range of descriptive data on the issue of alcohol consumption among young people with valuable information for this research gathered in extended periods of time and in multiple regions of the world. This offered the possibility of generating a broader understanding of the issue. However, throughout the discussion of the studies difficulties have been encountered in the interpretation of the data. For example, the reasons for the data were not always clear and therefore the explanations for the findings were at times hypothetical. Because of the fact that a large number of the population answers the survey the collected data offer a thorough description of the general population's characteristics. Surveys offer the possibility of revealing data that is close to the exact particularities of the larger population (Glasow, 2005). This exact data leads to precise results regarding the measurement of the data and limits the possibility of bias of the researcher. However, although the resulting data are very precise, the formulation of questions might sometimes be inappropriate as researchers need to standardise the questions before administering them to respondents. Questions tend therefore to be general in order to accommodate the general population. The validity of the studies is offered by sample representativeness. Most of the surveys included large samples of participants (e.g. SALSUS in 2010). External validity is also ensured by the surveys as the results can be generalised to the target population. The reliability of the surveys is proved by the consistency of questions, namely the results of the survey followed the aim of the research which was attained through the answers given by respondents to the survey. Moreover, reliability is also ensured by the repeatability feature, namely the same questions being answered in different periods of time by the same respondents reveal the same answers.

## **2.14 Conclusions**

Regarding worldwide alcohol use, young people tend increasingly to drink more alcohol the past decade. The top three most consumed alcohols are beer, wine and spirits; however, preferences differ by country. Family attitude toward alcohol directly affects young people's drinking behaviour. Young people who come from a single-

parent family tend to drink more than those who have both parents in the household. Social acceptance is a very important motive for young people to drink alcohol however they also state that they enjoy the taste and the effect that alcohol has on them. However, the level of drinking or drunkenness differs depending on the events. Males consume alcohol more than women.

In Thailand, the number of drinkers has increased especially in young people and women. Gender differences are the same worldwide: i.e. Thai men drink more than women, which is more acceptable in Thai society. Negative effects on school performance, monthly spending, and educational level are associated with drinking among young people. Alcohol policy and prevention strategies potentially contribute to reducing the harms of alcohol use worldwide.

Religious beliefs influence drinking culture; for instance Thais often provide alcohol for the holy image<sup>7</sup> and drink it after the ceremony has ended. In Thailand, Buddhism is a major religion as almost 95% there are Buddhists. According to the 'Five Precepts' in Buddhism, the fifth precept refers directly to alcohol consumption as it states that alcohol and illegal drugs should be avoided. Religion influences Thai practising Buddhist adolescents regarding alcohol consumption more so than non-practising.

It has become clear throughout this review that there exists an extremely complex relationship between culture and alcohol use. These complexities exist between different ethnic groups, different religious practices, the perception of gender and alcohol, and the views and attitudes of family member regarding alcohol use. Both universal patterns and unique practices are evident from analysing the use of alcohol cross-culturally. This complexity is particularly significant in terms of religious commitment, not just in Thailand, but also throughout the world. Although many religious practices warn of the negative consequences of alcohol consumption, many youths within these religious communities still engage in binge drinking, suggesting that their religion does not have a strong impact on their choice of drinking patterns. There seems to be a universal 'drinking culture', however within this universal culture, generally there are multiple differences and contrasts dependent on a huge array of

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<sup>7</sup> The image of God or angel

factors including family, environment, biology, gender, religion, culture, ethnicity, social norms and perhaps personal preference. It does seem clear however that culture does have a substantial influence on alcohol consumption worldwide. Although the purposes and reasoning behind alcohol consumption differs cross-culturally, the actual participation in alcohol consumption does exist all over the world.

This literature review is essential both for developing my survey questionnaire and for setting the schedule questions for the qualitative data collection, in terms of selecting the survey sample and in drawing up the questions so as to cover the most important areas involved in the issue of alcohol consumption among young people. Literature reviews are very useful for guiding how to develop questions which explain the characteristics of alcohol consumption by young people. Moreover, the information from literature reviews can clarify more in-depth information which questions in the questionnaire cannot access. The methods used in developing the questionnaire and details of the questions for the survey will be explained in Chapter Four and the questionnaire findings will be presented in Chapter Five. After that the qualitative approach will be explored in Chapter Six and its findings will be presented in Chapter Seven.

## Chapter 3

### Theoretical Framework

#### 3.1 Introduction

In the previous chapter, I provided information about young people and alcohol consumption, including young people's drinking in regions of Petchaburi province, with a focus on the UK and Thailand, the consequences of drinking alcohol, and the role of Buddhism in relation to alcohol use. This chapter presents a detailed account of the theoretical base which will be drawn upon and related to the study. Theories of child development and the ecological approach to health promotion are the main theoretical frameworks which will be applied to explain the characteristics and behaviour of young people's alcohol consumption.

In the first section I discuss the theories of child development and relate these to factors influencing adolescents' behaviour. In particular, I will discuss work from key theorists in an attempt to explore the reasons behind alcohol consumption among young people. Child development theories are therefore useful in the process of understanding the drinking onset, in accounting for reasons why young people start consuming alcohol, and in designing alcohol prevention strategies.

In the second section I will discuss the ecological approach and its application to health promotion in the context of young people and alcohol consumption. I have chosen this approach for the purposes of the present study because it acknowledges that there is an interactive relationship between the social environment and the behaviour and attitudes of the individual (McLeroy *et al.*, 1988) which is likely to explain people's behaviour. Consequently, the ecological approach will be used as a framework for my current analysis, in an attempt to account for the relationship between young people and alcohol consumption.

The Ecological Approach described above was used as the model on which I designed the participatory action research. This decision is justified by the fact that the Ecological Approach provided me with the necessary framework so as to include all stakeholders identified as important in the analysis of the young people's alcohol-related behaviour, focusing on the Petchaburi Province in Thailand.

The next section will define the ecological approach and relate it to adolescents' alcohol consumption behaviour. The approach is the main conceptual framework applied to the data in order to understand the participants' perspectives of young people's drinking.

## **3.2 Child Development**

I selected a number of child development theories to explore different aspects of young people's behaviour. These theories provide different lenses with which to focus on the sample population and to interpret the data. In the following sections I explore the key child development theories.

### **3.2.1 Definition of adolescence (young people)<sup>8</sup>**

The aim of this section is to clarify the definition of adolescents who constitute the sample for my study. Several definitions of adolescence have been provided, as it is an ambiguous concept that varies across cultures. As defined by Berk (2013), adolescence is a stage of human development that lasts from the age of 11 to 18. During adolescence, the transition to adulthood takes place when puberty results in sexual maturity and an adult-sized body. In the words of Berk:

*Thought becomes abstract and idealistic, and schooling is increasingly directed toward preparation for higher education and the world of work. Young people begin to establish autonomy from the family and to define personal values and goals. (Berk, 2013 p.6)*

It is a transition phase, which reveals the complexity of human development.

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<sup>8</sup> The term "young people" refers to all those between the ages of 11 and 18, and it may be interchangeable with the word "students", "children", "youth", "teenager" and "adolescence" in the text.

In Thailand, the definition of the adolescent period is defined slightly differently from region to region, but generally includes the age range of 10-24 years. The Thai expressions for adolescents and youth are often used interchangeably.

In Asia, perceptions about children refer to their innocence, lack of understanding and skills, as well as inborn goodness. Boocock (1991) states that the concept of innocence and inborn goodness is also present in Buddhist principles. Both Confucian and Buddhist principles advocate the fact that children are born good and remain this way until the adult world and their environment influence them (Chao and Tseng, 2002).

According to Weisz *et al.* (1993), when observing the way in which children are raised in Thailand, Thai adults teach their children that aggressive, disobedient or disrespectful acts and behaviour are not tolerable. Children in Thai families are usually taught to be polite and peaceful and to do their best in order to achieve a humble attitude that does not disturb others (Weisz *et al.*, 1993). Thai teenagers are also guided to avoid expressing their emotions, especially stronger ones such as anger. Regarding this cultural particularity, some researchers consider that apart from becoming polite and non-aggressive Thai teenagers may also develop forms of anxiety and inhibition (Boesch, 1977; Sangsingkeo, 1969; Suwanlert, 1974). Therefore, the cultural influences of parental education in Thailand might represent a cause for teenagers engaging in restricted activities such as alcohol consumption as a result of their multiple restrictions. The fact that one of the effects of over-controlled behaviour is anxiety and inhibition, might cause teenagers to turn to alcohol as a form of reducing their anxiety. Although adolescence is defined overall in the same way in Western and South-Asian culture when it comes to age or biological particularities, the primary social and cultural influences that Thai teenagers are faced with in their family represents the difference between the teenagers from the two regions.

This distinction is particularly important for the present study, as it accounts for the relationship that is established between the young people and the wider community of which they are part. In their 20s, most young people move away from home and start making decisions on their own, without being compelled to give any account of themselves to their families. At this stage, they take on their responsibilities, including



with regards to the issue of alcohol consumption, making it more difficult to design intervention programmes for that age group.

### **3.2.2 Developmental changes during adolescence**

For this research I have studied young people, therefore it is important to study and understand the theories which clarify their development. During adolescence, a significant amount of changes occur, the physical ones being the most easily observable. The main focus in this study will be on cognitive and emotional changes that appear in teenagers.

#### *Cognitive development*

Adolescence represents a vulnerable and essential period for normal and maladaptive developmental patterns. It has been portrayed as the period of transition from concrete operational thinking to abstract thinking, as well as the forming of reason and judgment. Recent research supports the idea that adolescent thinking represents a “*function of social, emotional, and cognitive processes*” (Steinberg, 2005 p.119). Research also supports the idea that the brain continues to develop during adolescence and in the early period of adulthood. During this period, the behavioural and cognitive systems, as well as the brain, develop in different proportions causing the adolescent to feel in a continuous state of vulnerability and adaptation (Gogtay *et al.*, 2004).

In the process of understanding the psychological development of adolescents, there are two main aspects that need to be considered. Firstly, during this period the brain is developing especially in areas that manage the adjustment of behaviour and emotions, as well as perceiving and evaluating risk and reward (Paus, 2005). Brain regions that deal with motor and sensory functions develop in the early teen period, while the reasoning area associated with managing impulses, emotions and executive functions complete their development (Luna, Padmanabhan and O'Hearn, 2010). Executive functions refer to the capacity to impede impulses, understand the consequences of decisions, make decisions, self-evaluate, self-regulate and make long-term plans.

The second important aspect in adolescent psychological development refers to transformations in arousal and motivation which precede the development of regulatory competence (Blackmore, Burnett and Dahl, 2010). The ventral striatum, which is the area of the brain responsible for reward, is also more operative during adolescence than in adulthood. Therefore, a gap is created between affective experiences and the capacity to manage arousal and motivation.

Research in the field of child development reveals three stages of adolescent cognitive development, namely early, middle and late adolescence (Cromer, 2011; Radzik, Sherer, and Neinstein, 2007). Specific to the early adolescence period is the dispute regarding authority and social standards which develop as a result of formal logical operations. The externalisation of thoughts and views appears characterised by choosing how to spend time. This is reflected in choosing peers, engaging in sports or questioning the rules imposed by parents. In this period there is little perception of long-term consequences of decisions. Personal decisions are very important for the adolescent in this period as well as the support of their peers (Cromer, 2011).

Middle adolescence is characterised by more complex thinking with increased interest in philosophical issues. Adolescents in the middle period have a tendency to question and over-analyse the issues they are confronted with in order to create their own identity and principles. Although at this stage they begin to understand the future consequences of decision-making, this is not yet applied. Peer-group influence is at a high level at this stage, which causes the emergence of conflict with parents. During this time teenagers are in constant search of sensations, which generates increased risk-taking behaviour (Radzik, Sherer, and Neinstein, 2007).

Late adolescence is characterised by the expansion of interests from self-centred concepts to global concepts, such as justice, history or politics. At this stage adolescents become independent and consider consequences before making decisions.

The cognitive development process during adolescence is very important for understanding the reasons why this period presents heightened risk for the appearance of behavioural problems, such as substance abuse (Cromer, 2011; Radzik, Sherer, and Neinstein, 2007).

## *Emotional development*

Adolescence represents a period characterised by significant changes with simultaneous but non-synchronous physical, cognitive and emotional development. Although for most teenagers this period implies appropriate changes, for some it may be a period of important challenges. The process of transition is from a time of conformity with parents' views specific to childhood, to a period of compliance with peer group principles and expectations, ending with the development of personal values through early, middle and late adolescence (Newman and Newman, 1999). A shift is registered between the emotional support of family members to the support of peers. Cognitive and emotional developments are directly connected to the brain's developmental stages in adolescence. Cognition reflects strongly on expressions of emotion, while emotions reflect on the teenagers' behavioural choices (Steinberg, 2005). Emotions play various roles such as generating positive behaviour, achieving goals, offering information about self and contributing to the creation of relationships (Larson and Brown, 2007). Sensitivity to rewards is significantly present in adolescence and can generate positive effects, such as academic achievements, or negative effects, such as use of addictive substances and high-risk behaviours (Sommerville and Casey, 2010). High intensity emotions, which have been termed as 'hot' and 'cold' cognitions, reflect strongly on the cognitive process of teenagers and consequently on behavioural decisions (Dahl, 2004). 'Hot cognitions' represent the thoughts that occur while experiencing high intensity emotions and lead to poor decision-making. 'Cold cognitions' are thoughts that appear in a state of calm which generate appropriate decisions. This can be used to explain spontaneous and often undesired poor decisions made by adolescents in 'hot' circumstances.

In order for teenagers to develop into socially integrated individuals with the capacity to make appropriate decisions that consider long-term consequences, it is important for them to have a healthy emotional development. Adolescents who do not manage to control their emotions risk making poor decisions that might generate an increased risk of substance abuse, delinquent behaviour or relationship challenges.

## *Parenting and teenager behaviour*

The influence of parenting represents one important factor that can influence the future drinking behaviour of children. Influences of inappropriate parenting can result in generating deviant behaviour, such as alcohol consumption (Mulvihill *et al.*, 2005). Family conflicts, marital instability or lack of discipline are factors that influence the future behaviour of the child (Kask, Markina and Podana, 2013). Child development and family studies have revealed the fact that the nature of the relationship between child and parent influences child outcomes. The interaction between child and parent is the only filter that can protect the child from the influences of the environment, such as the socio-cultural context of the family and the nature of relationships between family members (Kumpfer and Alvarado, 2003). The extent to which the parent manages to balance the amount of warmth and support on one side and supervision and discipline on the other, represents the main difference that can be made in the social-emotional and cognitive development of the child. Aggressive anti-social behaviour is created when this balance is not met and children develop forms of non-compliance in pre-school years. Later, non-compliance becomes a behaviour pattern characterised by low performance in school, by alcohol or drug abuse, and by alliance with deviant groups of friends (Jacob and Johnson, 1997).

The theories described above are useful for the purposes of this study in so far as they provide insight into the development of the young people and account for their attitudes and behaviour concerning alcohol consumption.

### **3.2.2.1 The Psychoanalytical Theory**

To answer questions regarding child and personality development, psychologists and sociologists (Berk, 2013) have emphasised that every child has a unique history that accounts for physical and behavioural differences among all children (Berk, 2013; Gesell, 1933). According to this perspective, the unique sequence of events and the family background of every child shapes his or her personality. This can be extrapolated to the young people's attitude towards alcohol consumption, as the 'unique history' of each child could account for habits and behaviour later on.

Thus, drawing on the findings of Freud and Erikson, Crain (2011), Bee and Boyd (2014) and Berk (2013) argue that when passing through a series of developmental stages (from early childhood to adolescence), individuals face conflicts between the expectations of society and biological motivation. In fact, in his Psycho-sexual Theory, Freud states that the first few years of child development are crucial for developing a healthy personality (Berk, 2013; Kail and Cavanaugh, 2008; Allen and Marotz, 2003). Therefore, the management of aggressive biological and sexual drives in this period sets up the overall personality of a child. The Psycho-sexual Theory emphasises three elements of human personality, namely id, ego and super ego, which can be used in the attempt to account for the adolescent's drinking habits. Considering the fact that the development of the three aspects of the human personality (id, ego, superego) starts early in childhood and, given that their healthy evolution is extremely important for their future becoming, any traumatic event occurring in childhood can turn into a trigger for delinquent or deviant behaviour, including alcohol and drug abuse (Martin, 2005).

All of the above mentioned theories perceive development as a consequence of the stages that need to be experienced and properly understood by the child in order to avoid possible future deviant behaviour that will have a negative impact on the life and health of the future adult.

Besides the model proposed by Freud, Crain (2011) and Berk (2013) draw attention to another theory that could be applicable in explaining young people's attitudes towards drinking, namely Erikson's stages of development. Erikson believed that 'ego' played a mediating role between the id and super-ego elements. The most significant point of Erikson's theory was the addition of three adult stages. This was in addition to the five-stage theory of child development of Freud's theory.

For the purposes of the present study, Erikson's stage of 'identity versus role confusion' (Berk, 2010 p.16) rooted in Freud's theory on the creation of the super-ego, is of particular importance, as it explains how young people take up the behaviour of adults –especially family members –and it accounts for the importance of role models in shaping the youths' behaviour (Smith, Cowie, and Blades, 2003). Erickson's

developmental stages are: trust versus mistrust; autonomy versus shame and doubt; initiative versus guilt; industry versus inferiority; identity versus identity confusion; intimacy versus isolation; generativity versus stagnation; and integrity versus despair (Oswalt, 2008). From Erickson's point of view adolescents are faced with solving life 'crises'. 'Crisis' is a term used by Erickson to portray a number of internal conflicts that are connected to developmental stages. According to his theory, the manner in which the crisis is solved by the person determines the future development of the teenager's personal identity. The crisis of identity versus identity confusion appears during early to middle adolescence and is characterised by a consistent search to balance the individual identity and the need to be accepted by peers. In Erickson's perception, when teenagers manage their crisis successfully the result is a clear perception of individual identity and readiness to share this identity with others. Consequently, they become confident people, well-integrated and can have relationships with others without losing their own identity. When the teenager fails to overcome a crisis they become uncertain about who they are and tend either to isolate or disconnect from their peers or to find a solution to adapt to the behaviour and principles of the peer group in order to be accepted (Oswalt, 2010).

One of the key strengths of psychoanalytic perspectives is its emphasis on the unique history of the individual and its role in shaping an individual's character and behaviour. However, in the views of Crain (2005) and Thomas (2005), these perspectives have limitations due to the lack of clarity about the concepts of ego and psychosocial stages.

In summary, the changes that occur in the development of teenagers have a significant impact on future behaviour. The influence of peers is primary as young people reach the early adolescence period, and at the same time, conflictual cognitions appear between identity and acceptance of the peers. Cognitions play a significant role in the generation of emotions which influence behaviour, and therefore, an important aspect in the prevention of alcohol consumption is appropriate management of emotions. This connects directly with the childhood period when the parents' response to the children's behaviour is very important in how they learn to perceive the expression of emotions. Regarding Thai youth, they are usually taught by their parents not to express their feelings, especially the most powerful ones. This might represent one of the

causes for turning to alcohol, as a form of overcoming inhibitions and anxiety arising from the lack of emotional expression.

### **3.2.2.2 Social Learning Theory**

Social learning theorists assess the abilities of behavioural approaches to explain the social behaviour of a child, and his or her development. Among many social learning theories, the imitation or observational theory of Bandura (1977) has proved to be an effective tool for exploring the child development process. As Bandura posits:

*The baby who claps her hands after her mother does so, the child who angrily hits a playmate in the same way that he has been punished at home, and the teenager who wears the same clothes and hairstyle as her friends at school are all displaying observational learning. (Berk, 2013 p.18)*

Other researches investigating the development of children and their evolution through all stages into adulthood (Coleman and Hendry, 1999; Goswami, 2008; Slater and Bremner, 2003; Slater and Muir, 1999) have also argued that children imitate everything in the beginning but then gradually become selective in the process. Furthermore, as posited by Seigal (2008), and Smith, Cowie and Blades (2003), children construct their own sense of efficacy and personal standards for behaviour. That is, based on the behaviour they witness, they build a model and try to internalise it, guiding their decisions based upon it. Self-efficacy is defined as the belief that their personal attributes and abilities will make them successful (Bandura, 1977). This prefaces the early adolescence stage when authority is being questioned and personal views begin to be expressed by the teenager. It is also a stage where children need to be encouraged in order to maintain this sense of efficacy as it aids confidence in adolescence when they are confronted with the influence of peers (Seigal, 2008; Smith, Cowie and Blades, 2003).

Social learning theories are important for the analysis of the young people's attitudes towards alcohol consumption, as they provide insight into the youths' behaviour, and their tendency to imitate adults (sometimes taking up their drinking habits). Therefore,

the framework of social learning theories will be used in explaining the reasons and motivations that influence young people to consume alcohol.

According to the theories on social learning, young people acquire behavioural norms and norms of social conduct in both a direct and an indirect way. The attitude towards drinking is made explicit to the adolescents by means of rules of conduct, social expectations as well as the overall consequences they are likely to have for the entire family and household. As Windle (2000) argues, in order for these rules to be assimilated, it is necessary that children are presented with them at a very young age, even before entering the adolescent stage, before they start relying to a greater extent on their peers than on their parents. Consequently, parents should discuss directly with their children about acceptable conduct, including as regards the consumption of alcohol. Otherwise, the desired behaviour can be presented indirectly to the youth, by the power of models. As posited by Peterson *et al.* (1994) a permissive alcohol behaviour witnessed at home by the child, or by the adolescent is perceived as adequate conduct, as accepted behaviour, and may subsequently lead to a similar behaviour from the latter. Furthermore, Andrews *et al.* (1993) argue that failure to discuss with the children in an open manner about matters regarding alcohol consumption may constitute a predictive element of adolescent alcohol consumption.

### **3.2.2.3 Cognitive Development Theory**

Modern theories of Child Development have been largely influenced by Jean Piaget and are opposite to those proposed by Behavioural Scientists (Cairns and Cairns, 2006).

According to Piaget (1971), children do not need any reward or stimulus for reinforcement of behaviour. Piaget believed that children construct knowledge during their daily life experiences. This theory was greatly influenced by Piaget's early training in biology. His theory originates from the central concept of biology called '*Adaptation*'.

Just as body structures can adapt to the external environment, the mind can also achieve improvement and fit in with the external world. Therefore, each child's



understanding of the environment and the world continues to change until a balance is achieved between the internal understanding of the child and the external world. Although Piaget's contribution to learning theories is vital, his theory has been challenged from a number of perspectives. For instance, Weiten (1992) has suggested that Piaget underestimated the capacities of infants and students. Criticism was also made of Piaget's excessive simplification of the stages (Carlson and Buskist, 1997), and to the insufficient attention paid to the effect that the cultural groups and the social contexts play in the development of the students (Weiten, 1992).

Piaget's stages of cognitive development include: the sensorimotor stage (birth to 2 years), pre-operational stage (2-7 years), concrete operational (7-11 years) and formal operational (11-15 years) (Piaget, 1971). The last stage is equivalent to the adolescence period. According to Piaget, in this stage hypothetical thinking and scientific reasoning are developing. The way children interact with their environment is also transformed in this stage along with the ability to plan and understand consequences of actions. Although social and cultural contexts are not much evident in Piaget's theory, the formal operational stage is perceived by the author as one of the significant changes in perception, especially the way they communicate to the outside world and vice versa. This indicates the same hypothesis that the environment is one of the main influences in the development of deviant behaviour, such as alcohol consumption. At this stage the way in which teenagers interpret the world around them is essential for the way in which they choose to act and behave in the future.

For the purposes of the present research, one aspect is particularly important, namely that of the impact of social and cultural groups (Weiten, 1992), which are equally likely to shape the young people's attitudes towards drinking. On the one hand, social and cultural groups may give rise to a desire of adherence to a particular group, and, thus, encourage young people to drink. On the other hand, the drinking culture of a particular region is equally likely to shape the youth's behaviour and attitudes towards drinking. Both these dimensions will be drawn on in Chapter 8.

The Social Cognitive Theory is particularly relevant to this study as it reveals issues of behavioural, cognitive and emotional behaviour, which are likely to account for an

individual's behavioural change. As posited by Bandura and Walters (1963), there is a very close relationship between three important elements, namely the environment, people and their behaviour. In other words, and following the position advanced by Glanz, Rimer and Lewis (2002), the environment is the one to provide behavioural models, which shape the individual's development.

For the purposes of this study, the Cognitive Theory is important as it provides for educational and behavioural programs, showing how individuals acquire and internalise and preserve given patterns. Moreover, as will be further shown, the Cognitive theory can also help in setting the foundation for designing strategies for intervention.

### **3.3 Ecological Approach**

Since the 1980s, the ecological approach has become a distinguished aspect of health promotion and disease prevention programs in the public health sector (Worthman, 2010). It has found applicability in several areas of health promotion, serving as a base for the development of intervention models. According to Gregg and O'Hara (2007), ecology finds its origins in the biological sciences and deals with the relationships between organisms and their immediate environment. Ecological models in public health emphasise the nature of a subject's transactions with their social, cultural and physical environment. The recent application of these models in research as well as in practice is significantly increasing. An ecological model can be described as a formalised application of environmental and individual factors that affects one's health and behaviour (Gregg and O'Hara, 2007). One of the fundamental theories of the ecological approach was proposed by Bronfenbrenner (1979), known as developmental psychology or socialisation theory. This is why I chose the ecological approach for my study.

I will now discuss Bronfenbrenner's (1979) ecological model before moving on to discuss McLeroy's (1988) adaptation of this model which I use in my study. The ecological model is particularly useful for explaining the connection and subsequent

relationships that are established between the individual (the young person) and the family, school and community environments.

### **3.4 The Ecological Approach**

#### **3.4.1 Bronfenbrenner's Ecological Model**

Bronfenbrenner's Ecological Approach was first published in 1979. It focuses on human development and identifies the ecological factors essential for an individual's adaptation to the social environment. The ecological system theory proposes different levels of environmental influences on human development (Bronfenbrenner 1979, 1986). Human development, as defined by Bronfenbrenner, is the process by which the individual acquires a deeper understanding of the surrounding environment, and encourage him/her to participate actively in actions concerning this environment. In addition, it enables individuals to maintain or restructure their environment at different levels including micro, meso, exo and macro systems (Bronfenbrenner, 1979).

According to Bronfenbrenner, an individual's development is affected by the diversity of their surroundings or environment which has an active interrelationship with that individual (Bronfenbrenner 1979). In order to understand the concept of environmental influence, the basic assumptions of this theory are addressed. Firstly, the individual is an active agent and influences his/her environment. Secondly, the environment compels an individual's adaptation to its settings and limitations. Thirdly, the environment is composed of different levels or entities having reciprocal relationships (Bronfenbrenner, 1979).

For a healthy intervention and prevention program, the micro-system would include the types of interaction found among family members, work groups and friends. It involves a pattern of engagements, roles and interpersonal relationships between an individual and a specific setting. Factors such as the temperaments, personalities, beliefs and culture of family and friends also constitute the micro-system. Worthman (2010) stated that the micro-system constitutes the immediate environment that the subject experiences, ensuring direct and face-to-face contact exchanges.

The meso-system consists of the physical family, education or work settings, while the exo-system is a larger entity including social systems, politics, culture, etc. Meso-systems comprise of processes and linkages between two or more micro-systems that contain the developing individual, e.g. the relationship between the family and the healthcare environment (Bronfenbrenner, 1979).

As shown by Bronfenbrenner (1979), the ecological model envisages the development of children as a sum of complex processes and interactions that are established between the youth and the broader social context. In other words, the micro-, meso- and exo-factors influence, to a broad extent, the development of the individual.

Therefore, the ecological approach considers meso-systems as a system of micro-systems. It is a second layer of environmental factors that encompasses all the micro-systems. Finally the exo-system consists of all the forces prevailing in a relatively large social system influencing the individual; for instance, the unemployment rates of a country influence the economic stability of individuals (Bronfenbrenner, 1979).

The concept of a macro-system has undergone many transformations since the introduction of Bronfenbrenner's theory. The influence of the macro-system and its role in the ecological approach has been predominantly critiqued (McLeroy *et al.*, 1988). Firstly, the concept of the macro-system was influenced by Vygotski's theory on the socio-historic evolution of psyches. According to Vygotsky, social interaction holds an essential role in the development of cognition, supporting the idea that social learning occurs before development. Therefore, cultural and social factors considerably contribute to cognitive development. According to Latkin and Knowlton (2005), it was mainly seen as the sociocultural context of the developing individual, and it will be discussed further in this chapter on the interpretation of the participatory action research conducted. It was developed by the idea that individual characteristics could accelerate an individual's development and learning under different environmental conditions. The original theory was defined as an overlapping pattern of different systems including micro, meso, exo and macro systems, characterised by different cultures and influenced by subcultures and other factors prevailing in the social context (Bronfenbrenner, 1979). The concept focused mainly on belief systems,

hazards, resources, constraints, opportunity structures, lifestyles, and social interactions, because these factors are embedded in all types of systems. It is the blueprint of a society based on its culture, subcultures and other social factors. All of these belief systems are perceived and integrated by children first in their family where they are represented by the behaviour of family members. The parenting methods used by parents convey messages to children on how they should behave in their future adult life. Children also perceive behaviour as good or bad depending on what type of behaviour they are confronted with and what their consequences are. In later work, Bronfenbrenner (1986) emphasised that conceptual and behavioural models operating in a macro-system are inherited by new generations through social and cultural institutions such as the family, congregation, school and workplace. Individuals who are part of the same cultural context have shared values, heritage and identity. The macro-system is constantly changing because each generation adds different patterns which all contribute to the development of a unique macro-system. This is of particular relevance to my study.

Irrespective of the level considered, from the micro-system to the macro-system, the surrounding environment is likely to affect the development of the individual, shaping his/her behaviour starting from the early years. In this study, the environment will be considered mainly in relation to the meso-systems. That is, in the attempt to assess the young Thais' attitude towards alcohol and drinking, I will consider factors that are connected to the young person's family background, his/her level of education or the study (or work) settings associated. Furthermore, the young people's attitudes will be assessed in relation to the exo-system that is in terms of the broader cultural, social or political system (McLeroy *et al.*, 1988).

### **3.4.2 The Ecological Approach in my study**

The review of literature reveals that the Ecological Approach in health promotion conceptualises reciprocal causative relationships between individuals and their environment (McLeroy *et al.*, 1988), which offers the rationale for selecting the ecological approach for this study.

The choice of the ecological approach is thus justified in the study by the important place that the environment occupies in the health and, implicitly, in the health behaviour of the individual. This influence can also be extrapolated to the issue of alcohol consumption, which has been assimilated to the study of personality traits in individuals.

These ecological models are also known as transactional models. Based on the Ecological Approach described above, different researchers have developed diverse models and frameworks and implemented them in the public health sector. For instance, Belsky (1980) combined Bronfenbrenner's ecological model with a development theory, and developed a framework to explore the impact of ecological factors (e.g. individual, social, and family, ethnic and cultural factors) on child abuse (Belsky, 1980). Bronfenbrenner's ecological model was also utilised in behavioural studies and the development of interventions on systems levels (Endler and Magnusson, 1976). Moreover, this ecological model was utilised for investigating distinct health lifestyles in different environments (Endler and Magnusson, 1976) and it was developed as a model for health problems based on behavioural and environmental factors (Lucie, Gauvin and Raine, 2011).

The ecological approach of McLeroy *et al.* (1988) was used in my research to understand the relationship between teenagers and the environment surrounding them, which has a significant effect on their health-related behaviour, as well as understanding the adolescents' attitude regarding alcohol consumption. This approach will prove itself also in the designing of the intervention programme aimed at helping teenagers to deal with drinking issues. The model of McLeroy *et al.* (1988) was consisted of five levels namely intrapersonal, interpersonal, institutional, community, and policy level.

Similarly, Michael Burawoy emphasised the importance of acknowledging existing social theory and the role of participant observation in collecting data and analysing the research environment, in terms of the 'micro' and the 'macro' levels of analysis (Burawoy, 1991). The 'micro' refers to the social situation of face-to-face interaction, and the 'macro' refers to the wider political and social systems which are reflected in

everyday life (Burawoy, 1991). In a number of studies Burawoy studied populations and corporations from a top to bottom and a bottom to top approach, such as the study on the Zambian copper industry with its focus on the Anglo American Corporation and the Roan Selection Trust (Burawoy, 2009). Burawoy extended out from the local (micro) world to look at the wider (macro) influences, allowing the discovery of multiple process, interests, and identities (Burawoy, 1991).

In the extended case method, Burawoy (1991) aims to investigate the effects that the 'macro' level is likely to have on influencing and shaping the 'micro' level. The 'micro' and the 'macro' levels can be interpreted as corresponding to the different levels of the ecological approach. Burawoy's analysis corresponds to the different levels of analysis of the ecological approach described as follows. In other words, in my study, the 'micro' referred to intrapersonal and interpersonal level, and the 'macro' referred to institutional, community, and policy level of ecological approach.

#### **3.4.2.1 Intrapersonal Level**

As defined by McLeroy *et al.* (1988), intrapersonal factors are the characteristics of an individual that influence the acquisition of knowledge and behaviour towards materials, events, personal beliefs, concepts, skills and developmental history. Health care professionals need to be aware of this information when they undertake a primary assessment of an individual and/or a community. It has been noted that most of the behavioural change models in health promotions are adapted from psychological theories and models (McLeroy *et al.*, 1988). Some psychological models are used to explore health-related attitudes and developmental programs, including attitude changing models, and value-expectancy theory. The psychological models utilised to develop health promotion and disease prevention programs aimed at altering adolescents' behaviour, adopt processes to enhance intrapersonal influences. For instance, the models of smoking addiction may involve concepts of excretion and nicotine metabolism, whereas peer group pressure may also be identified as a role model in adolescents' smoking behaviour (McLeroy *et al.*, 1988). Adolescents may feel tempted to take up their peers' habits and start drinking as a social act, an act granting them inclusion in a particular group.

According to the Health and Social Care Information Centre (2011; 2012; 2013), the report stated that adolescents who acknowledged more information of alcohol use and misuse, they should refrain from drinking it. Moreover, adolescents can be considered what the appropriate information source is useful of their knowledge.

#### **3.4.2.2 Interpersonal Level**

Interpersonal factors include the processes and factors related to primary groups such as family, friends and work colleagues. On this level, social networks include formal as well as informal groups, for instance, family, friends' network, work groups and other social groups. Members of these groups constitute the physical environment and behavioural influences of an individual according to behaviour, beliefs, social circumstances, economic conditions and education levels (Gregg and O'Hara, 2007). Additionally, the extended relationships of an individual's family, friends and neighbours significantly influence the health-related behaviour of the individual (Green and Kreuter, 2005; Jacob and Johnson, 1997; Casey *et al.*, 2010; Choudhury, Blakemore and Charman, 2006). For the purposes of my study, the most important factors considered as having a significant impact on shaping the young people's attitudes to alcohol consumption are the family members, relatives and friends (Kirke, 2006). These are likely to influence the young individuals' later drinking habits (Green and Kreuter, 2005).

According to Kirke (2006) the family is considered at the interpersonal level to be the closest social relationship for adolescents. Generally, alcohol consumption begins informally at home; however, parents might play an important role in providing education for their children in terms of alcohol consumption. For example, Rowe (1994) found that parents teach their children about the consequences of drinking alcohol and practice as a good model. Children also use their parents as role models to imitate. Moreover, studies on the influence of parents on adolescents' alcohol abuse (Rowe, 1994, Gregg and O'Hara, 2007) have concluded that parents play an important role in providing information but also in fostering young people's drinking behaviour. The findings showed that parents' roles influenced adolescents' behaviour



(Choudhury, Blakemore and Charman, 2006; Casey *et al.*, 2010; Jacob and Johnson, 1997).

In line with these findings I undertook focus group interviews with parents for my thesis to understand their views on: 1) adolescents' alcohol consumption behaviour; 2) factors accounting for adolescents' drinking; 3) the consequences of young people's drinking; 4) how to prevent children from alcohol use; and 5) how Buddhist practice in Thailand is important to prevent young people's drinking.

### **3.4.2.3 Institutional (or organisational) Level**

At the third level, McLeroy *et al.* (1988) suggested that institutional factors such as rules, procedures and regulations within the social structure impact on health behaviour. For instance, how policies on alcohol and smoking operate in educational and work organisations, have a direct impact on employees. Many people spend one third to half of their lives in an organisational setting; therefore, these organisations could facilitate both a negative and a positive attitude towards health issues, drug abuse, and early pregnancy. Organisational support and change programs could positively influence disease prevention programs (McLeroy *et al.*, 1988)

In my study, the institution considered as having the greatest say in shaping the young people's attitudes and behaviour in relation to alcohol consumption is the school. Especially in the context of Thai parents, such parents generally have high expectations from this institution as regards the instruction provided to students in these matters. Therefore, my analysis of the institutional factors will be focused on the schools in my study and the link between the school environment and drinking behaviour, the relevance and appropriateness of the school curriculum, and the implications and importance of education on alcohol and substance misuse, as well as the importance of carrying out and setting up preventative measures.

At the institutional (i.e. organisational) level, schools are considered the most likely organisation to provide alcohol education for students. Alcohol education is currently a part of a broad health education curriculum in high schools where all adolescents who attend school have the opportunity to access this information (McLeroy *et al.*,

1988). Also, Thai parents expect the school to be a good source of alcohol information for their children. For my study, in-depth interviews were carried out with advisory teachers to examine teachers' perspectives toward adolescents' alcohol consumption behaviour and school-based alcohol education. This method was used specifically to understand the teachers' perspectives on: 1) adolescents' alcohol consumption behaviour and consequences; 2) factors that account for students' drinking in school; 3) the importance of alcohol education and the current instruction on alcohol use and misuse in the educational curriculum; 4) how to prevent students from alcohol misuse; and 5) the necessity of Buddhist practice and alcohol use in the Thai context.

#### **3.4.2.4 Community Level**

At the fourth level (i.e. community), McLeroy *et al.* (1988) introduced the idea that the power of community factors can effectively enhance positive changes in behaviour towards serious health issues, alcohol consumption and drug abuse. At this level, diverse social institutions directly affect health promotion programmes. The concept of community power is one of the fundamental ideas of sociology and has been successfully incorporated into disease prevention and health promotion programmes throughout the world (WHO, 2009).

At the community level, in Thailand community leaders, healthcare providers and Buddhist monks have played a role in enhancing community health. Considerable amounts of training and campaigns have taken place in the community with support from community leaders and members that emphasise critical awareness and community problem-solving (WHO, 2009). In addition at the community level, the concept of partnerships and inter-agency collaboration is essential when addressing any health problems since one agency is unlikely to have sufficient resources and competencies to solve the complex problems on its own. One example is the 'Reducing harm from alcohol use in the community' symposium held in Bali, Indonesia in 2007 organised by The Mental Health and Substance Abuse Unit of the World Health Organization, Regional Office for South-East Asia which brought together representatives of the WHO in South East Asia and government representatives in the

attempt to identify policy and measures that can be taken to reduce the alcohol consumption levels in these countries and its devastating effects (WHO, 2009).

Community leaders, healthcare providers and schools should build collaboration to gain mutual benefits to address adolescent health problems. For instance, research has shown that schools should involve the community in developing an alcohol education curriculum (Committee on Developing a Strategy to Reduce and Prevent Underage Drinking *et al.*, 2004). At the same time, communities should collaborate with schools to provide health programs for young individuals in the community. For my research, in-depth interviews were conducted with community leaders and focus groups were conducted with healthcare providers to understand their perspectives toward 1) adolescents' alcohol consumption characteristics and the consequences; 2) factors affecting young people's drinking; 3) appropriate prevention strategies; 4) the connection between Buddhism and alcohol use; and 5) the community's roles in promoting adolescents' health.

#### **3.4.2.5 Policy Level**

Public policy factors are the final level of factors that influence public health promotion programmes developed on the basis of the ecological approach. McLeroy *et al.* (1988) have indicated that these levels operate on the assumption that health promotion programmes and interventions are based on individual beliefs, understanding, social beliefs, cultural factors and public policy.

Finally, at policy level, since 1999 the Thai government has been required by law to decentralise basic service functions to the local governmental administrative organisations (Wibulpolprasert, 2005), meaning that provincial authorities have to prioritise services. Policemen, on behalf of provincial authorities, have a duty to control and evaluate the government policies on alcohol misuse. As a result, it was found that many adolescents were arrested for fighting and crimes related to drinking alcohol. Additionally, anti-alcohol campaigns have been produced periodically by the Thai government (Wibulpolprasert, 2005). These programs are not effectively implemented or even modified based on involvement of the provincial authorities and

the organisational leaders who adopt them. These measures prove that the current policies for the control of alcohol consumption among young people are directed more towards combating the issue than preventing it. For my study, an in-depth interview was undertaken with the police to explore the policies which affect alcohol consumption by young people, in order to understand the police's views of: 1) adolescents' alcohol misuse and consequences; 2) the causes of young people's drinking; 3) the appropriate prevention strategies; and 4) the alcohol policy on adolescents' alcohol misuse.

The findings from my literature review demonstrated the need to (a) investigate the alcohol consumption behaviour of adolescents in Thailand, and (b) obtain a complete picture of perspectives regarding this complex issue by applying an ecological approach to the study of adolescents and the stakeholders with significant social influence. Table 3.1 below shows the application of an Ecological Approach to my study.

<b>Table 3.1 The application of an Ecological Approach to my study</b>		
<b>The original Ecological Approach by Bronfenbrenner (1979)</b>	<b>The application of an Ecological Approach in Health Promotion by McLeroy et al. (1988)</b>	<b>The application of an Ecological Approach in my study following the McLeroy et al. (1988)</b>
<b>Systems level</b>	<b>Levels of influence</b>	<b>Informants</b>
Micro-system	Intrapersonal Level	Students
Meso-system	Interpersonal Level	Parents/guardians
Exo-system	Institutional (Organisational) Level	Advisory teachers
Macro-system	Community Level	Community leader, healthcare providers, Buddhist monk
	Policy Level	Policemen

In summary, alcohol consumption behaviour is evident among many adolescents in Thailand. This risky behaviour leads to an increase in health, social and economic problems. However, the perspectives of stakeholders toward the alcohol consumption behaviour of young people are very important so as to identify what role they play in influencing young people's alcohol consumption and in implementing appropriate

prevention strategies. My study will explore the gaps in the literature to enable me to do this, by exploring the reasons and consequences of alcohol consumption among young people. This will be discussed further in Chapter Eight.

### **3.5 Action Research as a whole picture of my research**

Early in the design stage it seemed that one possible way to approach my study and to resolve the problem of so many young people's drinking would be to work together with the stakeholders in the community. In order to do this it was important to make the participants aware of the problems and then in some way empower them to try to find the best strategy to resolve the problem by themselves.

Moreover, in Section 3.4 and 3.4.1 I presented the importance and the origin of the Ecological Approach and in Section 3.4.2 I discussed the Ecological Approach as a framework accounting for the interaction between adolescents' behaviour and their environment, which influences their health behaviour. The Ecological Approach described above was used as model upon which I designed the participatory action research. This decision is justified by the fact that the Ecological Approach provided me with the necessary framework so as to include all stakeholders identified as important in the analysis of the young people's alcohol related behaviour, focusing on the Petchaburi Province in Thailand.

Furthermore, I have chosen 'Action Research' – a specific qualitative approach – on the grounds of its suitability for my study. Action research involves people in working together to identify and resolve issues arising for them within their communities (Reason and Bradbury, 2008). Since alcohol consumption among young people is an issue that reflects on the entire community, I have chosen Action Research as both the causes and the possible interventions need to be based on the community's perception of the issue. Reason and Bradbury (2008 p.4) defined Action Research as follows:

*Action research is a participatory process concerned with developing practical knowing in the pursuit of worthwhile human purposes. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical*

*solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities.*

From Reason and Bradbury's definition, action research is very suitable for my study as it allows for the participation of people in communities to apply theory to practice and to resolve the community's problems. Before clarifying my research design, I shall provide more information about Action Research.

### **3.5.1 The origin of Action Research**

In western countries, Action Research has been used in organisational development in teaching, health promotion and nursing, and even community development. Susman and Evered (1978), and Hart and Bond (1995) noted that Action Research was defined by Kurt Lewin which began a pioneering approach to social research. Similarly, Reason and Bradbury (2008) indicated that Action Research was widely used by social science researchers in the mid-1940s in the fields of liberal humanism, pragmatism, phenomenology, critical theory, systemic thinking and social constructionism. Then, Peters and Robinson (1984) commented that Lewin indicated that individuals' social behaviour was a function of their perceptions of their social context and its consequences. Marrow (1969) claimed that Alex Bavelas, one of Lewin's students, applied Action Research to enhance productivity in the workplace. He investigated ways of achieving productivity by inviting workers to participate in experimental change methods which have been described as a 'learning organisation'. Workers were encouraged to experiment with different methods and to discuss them among themselves. The methods that workers agreed upon were adopted in the workplace and then they found that they had increased their productivity after discovering and employing these new methods.

Furthermore, using participation to reduce the resistance to change was commented on by Coch and French (Reason and Bradbury, 2008). The experimentation was undertaken particularly to reduce resistance when new products and production methods were introduced. This shows that participative management methods are more effective when workers discussed changes with their supervisors. Reason and Bradbury (2008) commented that Lewin also inspired Ronald Lippit, his student, to

investigate the effects of different styles of leadership on conflict and performance within groups. The finding showed that only democratic groups exhibited both productivity and low levels of conflict. As a result, Lewin is famous for describing the effects on the behaviour of individuals and subsequently developed field theory which demonstrated that the behaviour of an individual was a function of personality and environment (Reason and Bradbury, 2008). Thus, Action Research became a democratically-based approach to the power of science to understand and change human behaviour (Reason and Bradbury, 2008).

Coughlan and Coughlan (2002) were additional proponents who defined Action Research as a scientific approach to research regarding human problems by directly taking action with people who experience the problems in order to identify the problems and investigate how to solve them systematically. Moreover, O'Brien (2001) similarly viewed Action Research as a technique of 'learning by doing' whereby people in a community identify a problem, and take action to resolve it. After that they evaluate the success of their efforts. If they are not satisfied with the results, they will try the cycle again. In term of Action Research, Coughlan and Coughlan (2002) indicated that it has four elements as follows:

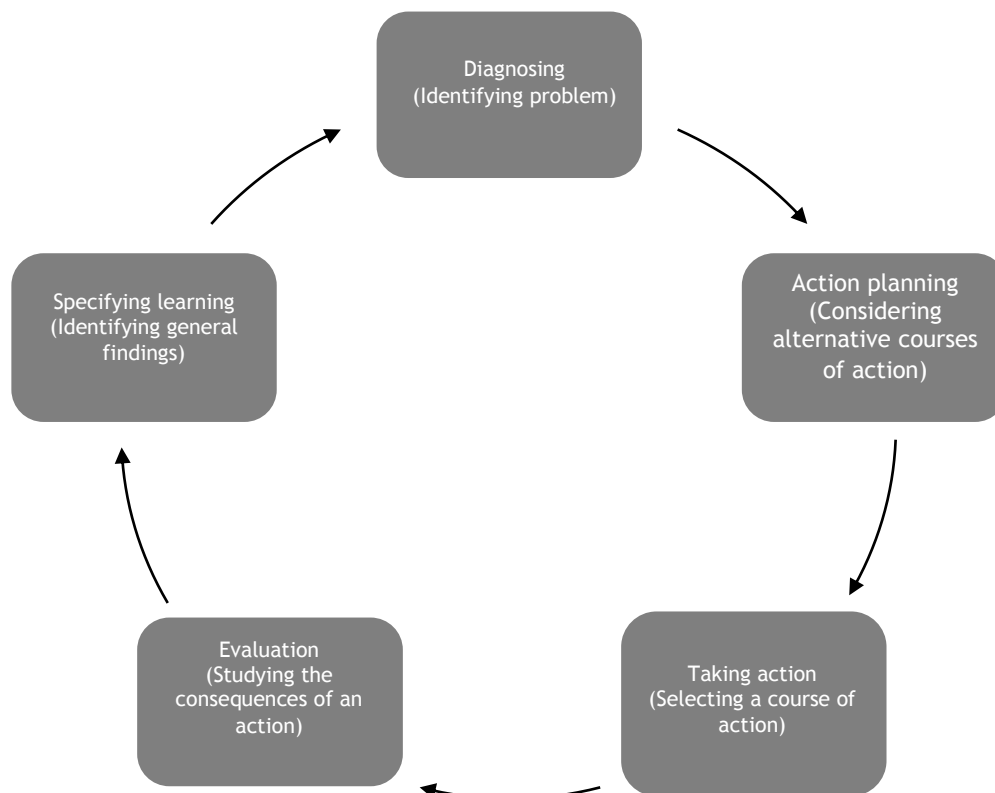
Firstly, Action Research focuses on research which is studying by doing and uses scientific approaches to study the resolution of community problems by people who experience the problems directly. Secondly, it is participative: people in the problematic situation have the right to participate actively in the process. Thirdly, it is a research method which is directed towards the promotion of effective action. Finally, it is an approach to problem-solving which involves the cycle of data collection, feeding back the concern, analysing data, planning action, taking action and evaluating, and then applying the results to the next cycle.

### **3.5.2 The process of Action Research**

The first step is to 'address or diagnose community problems' through collecting some preliminary data from relevant sources such as group meetings, police records, and surveys. When the problems have been identified, the next step is 'action planning',

devising a strategy for solving problems systemically. Next, ‘taking action’ is the process of collecting data directly from the people who are involved in studying the problems.

When the data have been collected and analysed, the next step is ‘evaluation’, using specific analytical methods to study the consequences of the actions. Finally, the results from the previous steps will be taken together to identify the evidence for the impact of the action or intervention in relation to the original problem. In this last step, the problems will be assessed and the evidence from this cycle would be used to re-assess the problems in another cycle with the same or alternative strategies. This process can be continued cyclically until the problem is resolved. Figure 3.1 below shows the cycle of Action Research adopted by Susman (1983). The details of how I applied action research are discussed in Chapter Six, Section 6.3.



**Figure 3.1 Action Research Model (Susman, 1983)**



### 3.5.3 Participatory Action Research

Action Research can be undertaken in many ways (Cronholm and Goldkuhl, 2003) as identified in Hart and Bond's (1995) typology: experimental, organizational, professionalizing, and empowering. Participatory Action Research (PAR) is a subset of Action Research (Udas, 1998) and sits at the 'empowering' end of action research (Hart and Bond, 1995). It is popular with social researchers who operate with members in an organisation to study and transform their organisation (Reason and Bradbury, 2008). According to Green *et al.*, "*participatory research is defined as systematic inquiry, with the collaboration of those affected by the issue being studied, for purposes of education and taking action or effecting change*" (Green *et al.*, 2003 p. 419). Also, Miller and Brown (1986) described the researcher's role in PAR as a facilitator: participants are thought of as researchers as opposed to being the objects of research. PAR is a participatory process where one develops practical knowledge for people who address the problems and understand the reason for people's actions (Chatterton, Fuller and Routledge, 2007). The difference between PAR and AR is that PAR uses the reflective practice of the researchers in the process, while in action research new insights are applied immediately to the next situation, and integrated into the ongoing process. This results in more creative solutions because the reflective practice converts perceptions of structural problems and their principles regarding the studied phenomenon in the process. PAR provides the opportunity for researchers and participants to make use of the capacities and wisdom of action research for the purpose of becoming drivers of social change at an organisational level.

Participatory Action Research (PAR) can involve quantitative, qualitative, or combined data-gathering methods, depending on the issue under investigation. As I describe above, I wish to engage with individuals, groups, communities and the wider environment in my research which makes PAR particularly suitable for the study of young people's alcohol consumption, starting from a quantitative base (phase one of my study).

The terms 'collaborative inquiry' or 'participatory action research', which facilitates engagement with participants through relationships, are often used interchangeably in

health care research (Koch and Kralik, 2006 p. 13). In action research the researcher is not involved in change actions, whereas in PAR action is integrated into the research itself (Koch and Kralik, 2006). Both researchers and participants act according to self-devised plans to take social reform onto a macro level or to take continuity into individual lives on a micro level, that is, by means of collaborative work directed to the macro-level (the surrounding environment, the community), action is ultimately taken for the well-being of the individual (Koch and Kralik, 2006).

### **3.5.4 Participatory Action Research process**

According to the Action Research process, PAR works through three basic phases: *'Look', 'Think', and 'Act'* (Stringer, 1999 p. 145). *'Look'* means the group observing the situation, gathering information, and defining and describing the issue. From the researcher's perspective, *'look'* also means building a picture of the research setting and relevant events, identifying the key stakeholders in the research, and locating relevant documents, literature and records. *'Think'* is stimulated as the researcher (facilitator) asks participants to reflect on the emerging picture, and the contributing story. The facilitator encourages participants to engage in discussion and describe their experiences in the evaluation process, the facilitator and participants judge the worth, effectiveness, appropriateness, and outcome of activities, and then they formulate solutions for issues.

In this way participants can learn from the experiences of others. *'Act'* is resolving the issues. This reveals another difference from the action research particularity of the researcher gathering knowledge from which the group can learn as well. In PAR, the intention is for participants to achieve knowledge on the phenomenon within the group. Also, in PAR the *'expert'* is missing, with the problems, actions and knowledge of the participants being highlighted. The main characteristic of PAR is creativity in finding solutions, while in AR the purpose is for improved capacity and knowledge. As above, the PAR process was developed from the basic process of Action Research, simplified as a cyclical model, in which each cycle consists of the following five steps (Susman, 1983); 1) diagnosing or identifying problems, 2) action planning, 3) taking action, 4) evaluating, and 5) specifying learning or reflecting a body of knowledge.

### **3.6 The methods used for data collection**

The first stage of my research has involved the application of a set of questionnaires to the target population. The second phase of my study involved Participatory Action Research which relied mainly on qualitative data collection methods. Discussing qualitative data collection methods employed in action research, O'Brien (2001) has suggested a variety of options. The common methods include: keeping a research journal, documenting data collection and analysis, participant observation recordings, questionnaire surveys, structured and unstructured interviews, and case studies. The most popular methods which researchers use for qualitative data collection are focus group interviews and in-depth interviews.

In this study, the focus group interviews were carried out with secondary school students, parents and guardians, and healthcare providers. Focus groups have been chosen because they allow me to gather information in the 'real world' context because the method relies on peer to peer interaction. In-depth interviews were conducted with a community leader, advisory teachers, a policeman, and a Buddhist monk. Interviews were chosen for collecting detailed in-depth information from an individual perspective in the situation of the participants who could not join the focus group. Moreover, controversial or sensitive topics are preferably tackled in face-to-face conversation. More details about the focus groups and in-depth interviews in my study are given in Chapter Six. The following sections elaborate on the use of focus groups and in-depth interviews and the underlying concepts.

#### **3.6.1 Focus group**

Focus groups or as some researchers call them, 'participatory action research groups' (Koch and Kralik, 2006) are a qualitative data collection method. A focus group is a carefully planned discussion, designed to obtain the perceptions of group members on a defined area of interest (Langford and McDonagh, 2003). Therefore, a focus group is an approach to obtaining in-depth thoughts, understanding, and beliefs about a particular issue through a structured group discussion, or gaining impressions and

perceptions of existing proposed services, products, programmes or organisations (Langford and McDonagh, 2003).

A focus group aims to obtain the collective viewpoint whereas a one to one in-depth interview aims to gain an individual's viewpoint. It provides the opportunity to obtain an in-depth understanding of the topic being explored. The key benefit is that, besides the fact that the researchers interact directly with participants, the participants can also interact amongst themselves (Langford and McDonagh, 2003). Grudens-Schuck, Lundy-Allen and Larson (2004) noted that focus groups provide researchers with unexpected information more than other types of research methods. The method is particularly useful for allowing participants to generate their own questions, frames of reference and concepts (Barbour and Kitzinger, 1999).

However, there may be cases where the dominant view closes down more marginalized views (Krueger and Casey, 2000). Research shows that conformity and inhibition may appear as a result of some participants feeling they have a different perspective from others, or even feeling that what they think about the issue has already being stated by the group members (Barbour and Kitzinger, 1999). During the focus group process, the researcher can observe emotions, expressions, contradictions, and tensions that confirm not only the participants's stories, but also the connotation behind these stories (Barbour and Kitzinger 1999).

Typically, focus groups involve five to twelve participants with the same socio-demographics or similar experiences, participating in a dynamic discussion with the help of a skilled moderator (Langford and McDonagh, 2003). While Doody, Slevin and Taggart (2013) said the number of people in a group can range from four to twelve, a researcher must consider what the most workable size is, which depends on the background of the participants and the complexity of the topic. Similarly Bloor *et al.* (2001) claimed that the size of group can range from as small as three participants up to fourteen. Focus groups usually last from one to two hours and the duration usually relates to whether the topic is specific or broad and the number of questions to be asked (Doody, Slevin and Taggart, 2013). Thus, while a large group of participants may

ensure extensive knowledge on the issue, on the other hand, the entire process may get drawn out and thus be detrimental for both the participants and the researcher.

The location and time for focus groups must be considered as well as important practicalities such as seating and room layout, accessibility, and the time of the meeting (Koch and Kralik, 2006). For example, in my study when collecting data from parents, it would have been unwise to plan a group meeting during working hours or at the time of day when they go to the rice fields. The time of the meetings and the setting should be mutually agreed by participants. When I arranged the times to meet with the participants included in my study, I had to adjust to their schedule and availability. It is important to ensure that sufficient time is allowed for participants to chat and, if it is the case that they were previously strangers, get to know each other. This encourages relationship-building that is so important within the PAR process. Nonetheless, refreshments should be provided because the offering and sharing of refreshment also helps to create a relaxed and friendly atmosphere and reduces the formality of a round table layout (Krueger and Casey, 2014).

Koch and Kralik (2006) said that it is important for the group to develop norms which permit participants to share and work through uncomfortable emotions and experiences, and as Langford and McDonagh (2003) also comment, it is essential to establish basic rules for the discussion. The researcher should ask participants to consider what is important to them in a group environment. The group norms are devised from their responses and often revisited at subsequent group meetings. During the meetings organised throughout my research, I paid attention to anything that could affect the participants, such as feeling uncomfortable or left out of the discussion, trying not to offend them in any way or to cause them any kind of embarrassment. I tried to provide a comfortable environment so as to encourage them to be open and to feel at ease when sharing their experiences. I valued their opinion and I encouraged the entire group to respect the others' opinions and experiences. The ethical considerations will be detailed later in Chapter Six.

Langford and McDonagh (2003) suggest that a good introduction is required in order to prepare participants for the research session and to help them to feel welcome. This

might be done through formal introductions to each other when first meeting and then allowing space for participants to get to know each other (Koch and Kralik, 2006). The facilitator has to keep a watchful eye on the developing group dynamics. When conducting the focus groups, I sometimes had to work more on drawing the informants to talk. Firstly I had to give them some directions, and ask questions, to stimulate their thinking. During the discussion at subsequent meetings participants are invited to share their stories. They tend to place emphasis on aspects and experiences that are important to them. Personal agendas begin to be revealed and cohesion within the group becomes evident. As the participants share their stories, the group begins to form an identity. When all participants have been heard, they will begin to assist each other to explore common strengths, problems and issues, and to formulate experiential accounts of their simulations. In Chapter Six, Section 6.5 I shall present how I used the focus group interview in my research in particular to collect data from the groups of students, parents and healthcare providers.

### **3.6.2 In-depth interview**

In-depth interviewing is a qualitative research method and widely used to explore personal experiences, responses and opinions. In-depth interviews are characterised as being loosely structured, given the fact that sometimes they are not even drafted prior to the interview (Kvale, 1996).

As pointed out by Weiss (1994), interviewing provides us with opportunities to make observations of others. Moreover, we can learn about people's culture, norms and experiences, and gain perceptions of their interpretation, feeling and thoughts, and the meanings from their work in order to 'read people's minds'.

Similarly Koch and Kralik (2006) said that one-to-one interviews are particularly useful for gaining in-depth understandings about the personal context behind a participant's experiences because they allow interviewees to feel more comfortable in sharing their experiences and not being faced with a groups's opinions. Boyce and Neale (2006) noted that an in-depth interview method involves intensive individual interviews with a small number of participants to explore their perspectives on

particular topics or situations. Information is obtained through a structured conversation between an interviewer and an interviewee (Patton, 2002). Liamputtong and Ezzy (2005) indicated that the quality of the interview is largely determined by the interviewer. Some interviewer techniques to improve the quality of an in-depth interview include:

- Using warm-up questions at the onset of the interview to build rapport between the interviewer and interviewee
- Having strong listening skills is necessary for the interviewer
- Observing non-verbal communication such as facial expressions of confusion or if an interviewee struggles with a response
- Using different and clarifying words when repeating a question
- Waiting until a full response is made by the interviewee instead of interrupting while an interviewee is talking when new questions emerge, and
- Asking one question at a time.

Koch and Kralik (2006) commented that several research studies show that participants requested one-to-one interviews with researchers in addition to participating in the participatory action research group process. Some participants may be reluctant to speak out in a group situation, unable to attend a group due to a health problem, have busy work, or perhaps want to share an intimate aspect of their story with a researcher. Relationship-building is very important for the in-depth interview. The researchers have to engage with participants so as to promote comfort, trust and safety. The time and place for the interview should be comfortable for the participant. It is important that the researchers identify themselves, discuss the area of interest and the background to the research, and follow ethical guidelines with regard to informed consent (Koch and Kralik, 2006). In Chapter Six, Section 6.5.2 and 6.6.2 I will illustrate how I used the in-depth interview in my research in particular to collect data from a community leader, advisory teachers, a policeman and a Buddhist monk.

### 3.7 Conclusions

The focus of this chapter has been on presenting in detail the theories that will be employed in the analysis of the issue of young people and alcohol consumption with a focus on the chosen sample population.

The first section of the chapter explored theories of child development, with a view to understanding the factors that are likely to influence the adolescents' behaviour, including in relation to their drinking behaviour. Thus, as previously discussed, Child Development is a multilevel approach which starts from infancy to adulthood. Different theorists have proposed models for exploring and understanding the process of human development and learning. Early historical theories provided the basis for modern theories. Learning has been explained from psychological, analytical, social and biological perspectives. Finally, this section has also provided a discussion of various factors that could affect adolescents' behaviour towards excessive drinking and substance abuse. The key factors identified that influence adolescents' behaviour include: their family structure, parents, family members, peer groups, school environments, media, advertisements and culture.

The second section of this chapter was directed towards the ecological approach and its application to health promotion, with a focus on the issue of young people and alcohol consumption. As discussed in this section, the Ecological Approach describes the interaction between persons and their surrounding environment which influences their health behaviour. An Ecological Approach is also recommended for understanding adolescents' behaviour with regards to alcohol consumption. Moreover, the Ecological Approach is discussed in health promotion programmes, which is very useful for developing prevention programmes for promoting young people's health. The concept of the Ecological Approach is categorized into five levels: intrapersonal, interpersonal, institutional, community and public policy which was applied following McLeroy *et al.* (1988) and developed from Bronfenbrenner's original concept (micro-systems, meso-systems, exo-systems and macro-systems).



Finally, Participatory Action Research theory is discussed in this chapter, as a research approach suitable to study community problems for which all stakeholders are responsible for solving. According to the PAR concept, the cooperation of community members is needed, thus the stakeholders are the key people to share their ideas and find the appropriate alternative courses of action to resolve community problems.

The previously described theoretical PAR framework will be operationalised in this study through the in-depth interviews and focus groups.

Thus, drawing on the literature review in the chapter and presenting the theoretical framework to be employed in the assessment of the issue of alcohol consumption of young people in Thailand, the next chapter will introduce the methodology employed in conducting the survey questionnaire. The questionnaire results will be further analysed in Chapter Five, in order to identify the problems to be addressed in the Participatory Action Research phase of the study, to further clarify the situation of young people's drinking and to identify possible prevention strategies.

## Chapter 4

### Phase One – The Survey

#### 4.1 Introduction

In this chapter I describe the research method for the survey which was the first phase of my research. The aim of the survey was to identify the characteristics and problems of alcohol consumption behaviour of young people in Petchaburi Province, in preparation for the second phase (Participatory Action Research). In the following sections I describe the research method for phase one which gives details of the study sites, participants, tool development and application, validity and reliability, data collection, analysis and ethical considerations.

#### 4.2 Study sites of the survey study

The survey was undertaken in Petchaburi Province, Thailand, a medium sized province located in the western part of Thailand which borders Myanmar and is close to the Gulf of Thailand on the east. Before I came to Edinburgh for my PhD, I had worked in this province for more than 20 years as a nurse lecturer in a nursing school. That enabled me to gain a thorough knowledge of the background of the area and the health problems in this province. From the literature review presented in Chapter 2, I found that there were no studies of alcohol consumption by young people in Petchaburi Province, even though this is an issue faced by the people in this community. As a result of my experience and the literature, I decided to do my research in this particular province.



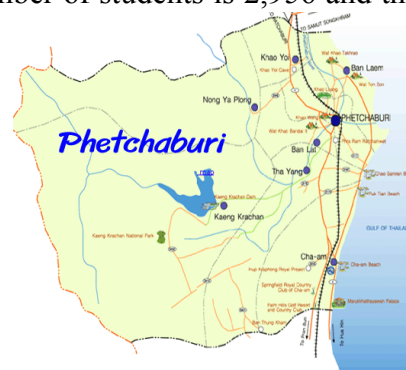
**Figure 4.1 Map of Petchaburi Province**

The survey was carried out in the eight districts of Petchaburi Province as follows: 1) Mueang Phetchaburi, 2) KhaoYoi, 3) Nong Ya Plong, 4) Cha-am, 5) Tha Yang, 6) Ban Lat, 7) Ban Laem, and 8) Kaeng Krachan.

The total number of secondary schools in Petchaburi Province is 22. However, due to the time that would be required to collect data from all 22 schools, I discussed the matter with my supervisors and the director of the Petchaburi Secondary Education Service Area Office 10 and we agreed that I should collect and analyze samples from one school in each of the eight districts. The selected school from each district was given a pseudonym in order to maintain the anonymity of the data. The school pseudonym ‘A-H’ is given in all cases instead of the district name. The lists below are the survey locations which are in different areas and at various distances from the centre of Petchaburi Province.

1. School A is located in a city centre. The total number of students is 2,956 and the number of students in Matthayomsuksa 4-6 (Grades 10-12) is 1,539. The sample size is 156 students.

2. School B is located in an agricultural area, and near to the main road to the village. This school is close to rice fields, gardens and an agricultural product market. It is about 20 kilometres from the city centre. The total number of students in this school is 1,043 and the number of students in Matthayomsuksa 4-6 is 419. The sample size is 135 students.



**Figure 4.2 Map of district locations for the survey**

3. School C is also located in an agricultural area and near the highway. It is about 30 kilometres from the city centre. This school is close to rice fields and a Buddhist temple. The total number of students in this school is 811 and the number of students in Matthayomsuksa 4-6 is 236. The sample size is 85 students.

4. School D is located in an agricultural area and near the main road to the village. It is about 12 kilometres from the city centre. The total number of students in this school

is 1,623 and the number of students in Matthayomsuksa 4-6 is 721. The sample size is 80 students.

5. School E is located in an agricultural area and close to a fishermen's village, which has many foreign labourers. It is around 12 kilometres from the city centre. The total number of students in this school is 595 and the number of students in Matthayomsuksa 4-6 is 231. The sample size is 79 students.

6. School F is close to the Thailand – Myanmar border, far away from the city centre and in rather a desolate area. There is a hill tribe in this area. The school is surrounded by forest and is 50 kilometres from the city centre. The total number of students in this school is 579 and the number of students in Matthayomsuksa 4-6 is 187. The sample size is 79 students.

7. School G is close to the Gulf of Thailand and is about 45 kilometres from the city centre. The school is near the highway to the southern part of Thailand and close to a famous seaside beach, where there are many tourists. The total number of students in this school is 1,176 and the number of students in Matthayomsuksa 4-6 is 582. The sample size is 142 students.

8. School H is close to the Thailand – Myanmar border and about 65 kilometres from the city centre. This school is surrounded by forest and close to the main road to a large dam. The total number of students in this school is 606 and the number of students in Matthayomsuksa 4-6 is 210. The sample size is 89 students.

### **4.3 Participants**

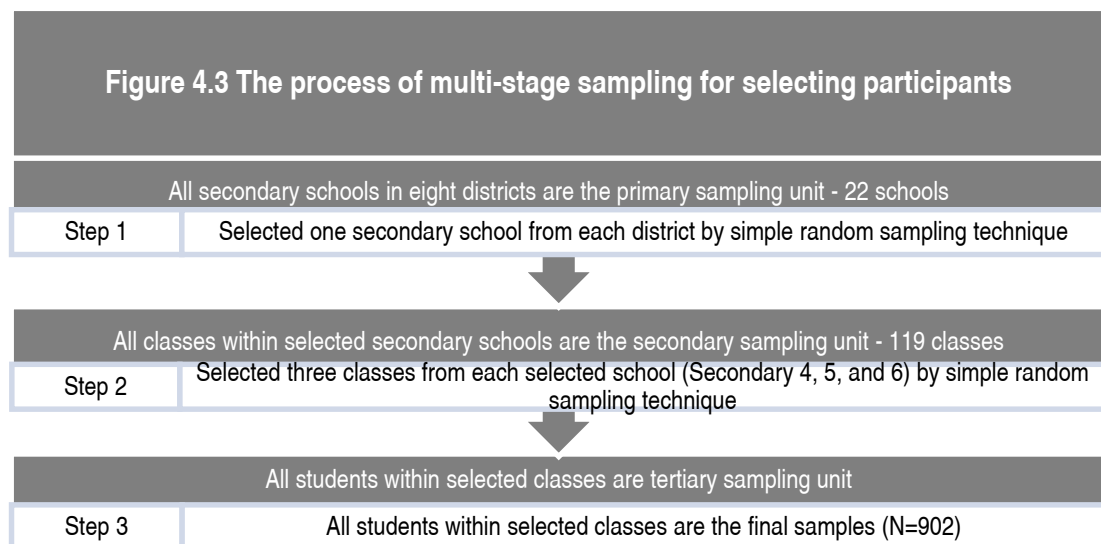
The participants in the survey were secondary school students, currently studying in Matthayomsuksa<sup>9</sup> 4, 5 and 6 in these eight districts. The total number of secondary school students in the eight schools was 4,125 and the samples drawn from them were collected and analyzed during this study.

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<sup>9</sup> Secondary school level

I was concerned that the study should be undertaken in all eight districts in order to cover all districts in Petchaburi Province where there are a variety of geographic and demographic differences. As I could not study the total population of the school students in the age range, a strategy was needed to obtain a representative sample. Multi-stage sampling provided a useful approach for this purpose. Multi-stage sampling is done sequentially across two or more hierarchical levels (Battaglia, 2008). For the purposes of my study this took place firstly at the provincial level, secondly at the district level, thirdly at the school level, and fourthly at the classroom level.

In my survey, multi-stage sampling was used to ensure that the target populations studying in 22 schools in eight districts across Petchaburi Province were represented. First it was used to select the schools, then the classes and finally the students. In consultation with the director of Petchaburi Secondary Education Service Area Office 10, the Petchaburi Province schools' database was used as the sampling frame and all district secondary schools were included in the primary sampling unit (PSU) - 22 schools, and then eight schools were randomized by simple random sampling technique (Parahoo, 2014). Simple randomization involved allocating each school a number and placing all of the schools for one district in a 'hat' from which there was an equal chance of them being picked. One school was then drawn as representing the district. This process was repeated for each district. In total, 109 Matthayomsuksa 4, 5, and 6 classes within each of the selected schools remained in the secondary sampling frame, and the total number of students in selected classes constituted the final sample. The following figure shows the steps of how I selected the samples for my study.



### *Step One: Sample schools selection*

The first step of the multi-stage sampling aimed to define the target population and is called the primary sampling unit (PSU). This was the total number of secondary schools in Petchaburi Province, which was 22 in this primary unit. Then I divided all secondary schools into eight groups which followed the district geographical area, and I randomized one school from a particular district in order to represent the characteristics of young people that covered all Petchaburi Province. For this step, the simple random sampling technique was used to select one school from each district and I then secured eight schools as the main sampling units.

### *Step Two: Sample classes selection*

The second step aimed at selecting the classes from the secondary sampling unit. In my study, 109 Matthayomsuksa 4, 5, and 6 classes from within each of the schools selected in Step One remained in the secondary sampling unit. In consultation with the Advisory Teacher, I used purposive sampling (Parahoo, 2014) to generate a pool of 39 classes which would be available for data collection during the period of my fieldwork. I then used the same simple randomization as I had done previously to select one class

from each Matthayomsuksa 4, 5 and 6 for each school. I have described the sample in detail in Table 4.1.

### *Step Three: Samples*

After I had selected classes for my sample site, the total number of students in each selected class was my sample. Hence, the total number of students in my study was 902. My actual sample was 845 students because 57 were absent and went to extra courses such as ROTC (Reserve Officer Training Corps) and Academic Contest. However, I obtained 845 questionnaires, resulting in a 93.68% participation rate which is extremely high. In the final stage all the students in each class were included in the sample. The sample size from each school is shown below:

<b>Table 4.1 The sample size of each school</b>												
<b>School</b>	<b>Secondary 4</b>			<b>Secondary 5</b>			<b>Secondary 6</b>			<b>Total</b>		
	<b>Boy</b>	<b>Girl</b>	<b>All</b>	<b>Boy</b>	<b>Girl</b>	<b>All</b>	<b>Boy</b>	<b>Girl</b>	<b>All</b>	<b>Boy</b>	<b>Girl</b>	<b>All</b>
School A N	16	34	50	24	30	54	31	21	52	71	85	156
School B N	20	30	50	19	32	51	14	20	34	53	82	135
School C N	12	18	30	13	16	29	13	13	26	38	47	85
School D N	9	19	28	13	9	22	11	19	30	33	47	80
School E N	10	15	25	13	14	27	13	14	27	36	43	79
School F N	7	21	28	16	12	28	17	6	23	40	39	79
School G N	17	26	43	20	28	48	19	32	51	56	86	142
School H N	12	10	22	17	17	34	18	15	33	39	50	89
<b>Total N</b>	<b>95</b>	<b>181</b>	<b>276</b>	<b>135</b>	<b>158</b>	<b>293</b>	<b>136</b>	<b>140</b>	<b>276</b>	<b>366</b>	<b>479</b>	<b>845</b>

1. School A: in total, 1,539 students in secondary 4, 5, and 6 classes remained in the sampling unit. The sample size was 156 students where the participating classes were Secondary Class 4/10, Class 5/10, and Class 6/10.
2. School B: in total, 419 students in secondary 4, 5, and 6 classes remained in the sampling unit. The sample size was 135 students where the participating classes were Secondary Class 4/2, Class 5/2, and Class 6/1.
3. School C: in total, 236 students in secondary 4, 5, and 6 classes remained in the sampling unit. The sample size was 85 students where the participating classes were Secondary Class 4/2, Class 5/2, and Class 6/2.
4. School D: in total, 721 students in secondary 4, 5, and 6 classes remained in the sampling unit. The sample size was 80 students where the participating classes were Secondary Class 4/2, Class 5/2, and Class 6/2.
5. School E: in total, 231 students in secondary 4, 5, and 6 classes remained in the sampling unit. The sample size was 79 students where the participating classes were Secondary Class 4/2, Class 5/2, and Class 6/2.
6. School F: in total, 187 students in secondary 4, 5, and 6 classes remained in the sampling unit. The sample size was 79 students where the participating classes were Secondary Class 4/2, Class 5/2, and Class 6/2.
7. School G: in total, 582 students in secondary 4, 5, and 6 classes remained in the sampling unit. The sample size was 142 students where the participating classes were Secondary Class 4/2, Class 5/2, and Class 6/2.
8. School H: in total, 210 students in secondary 4, 5, and 6 classes remained in the sampling unit. The sample size was 89 students where the participating classes were Secondary Class 4/2, Class 5/2, and Class 6/2.

The following table shows the process of how the samples were recruited from the target population in the eight districts.



Table 4.2 The participant recruitment from eight districts										
District name	A	B	C	D	E	F	G	H	Total	Sampling method
Total schools	6	3	2	1	3	1	4	2	22 schools	
Step 1. Selecting one school from each district	School A	School B	School C	School D	School E	School F	School G	School H	-	Simple random
Total classes in Secondary 4, 5, 6	36	12	8	18	6	6	15	8	109 classes	
Step 2. Selecting available classes in each school	7	6	3	5	4	4	6	4	39 available classes	Purposive
Step 3. Selecting one class from each year	3 Class 4/10, 5/10, 6/10	3 Class 4/2, 5/2, 6/1	3 Class 4/2, 5/2, 6/2	3 Class 4/2, 5/2, 6/2	3 Class 4/2, 5/2, 6/2	3 Class 4/2, 5/2, 6/2	3 Class 4/2, 5/2, 6/2	3 Class 4/2, 5/2, 6/2	24 Selected classes 902 students	Simple random
Samples	156	135	85	80	79	79	142	89	845	

## 4.4 Tool development and application

### AUDIT

Within the literature that I reviewed there are examples of a number of validated measures of alcohol consumption. The majority of studies in the review used the Alcohol Use Disorders Identification Test (AUDIT) which was developed by WHO (Babor *et al.*, 2001) for conducting research about alcohol consumption. At first I considered that the AUDIT was suitable for my research because it had been developed for screening for excessive drinking alcohol in order to help the practitioner identify people who exhibited hazardous drinking, harmful drinking, and alcohol dependence (Babor *et al.*, 2001). However, the questions in the AUDIT questionnaire were clinically focused and intended to identify problem drinking and that was not a good fit for my study. My study needed a tool to collect data which described the multi-faceted characteristics of young people who consume alcohol, such as demographic data, family members' drinking behaviour, location of drinking, consequences of drinking, purchasing alcohol, family attitude towards young people's drinking, and other factors.

### SALSUS

After I decided that AUDIT was not suitable for my study, I reviewed previous studies and discovered research into adolescent lifestyle and substance use. One such study is the biennial Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) (Black *et al.*, 2008) which was suitable for my study. In comparison to AUDIT, SALSUS is a survey on smoking, drinking and drug use amongst secondary school students in Scotland. The survey targets young people aged thirteen to fifteen years old in order to monitor a national picture of their smoking, drinking, and drug use behaviour within the context of other lifestyle, health and social factors (Black *et al.*, 2008).

According to my review of the literature, the SALSUS was found to have been widely used in Scotland by a range of agencies including the social research organizations

Ipsos MORI Scotland and the British Market Research Bureau. It has also been used in academic studies carried out by the Child and Adolescent Health Research Unit (CAHRU) at the University of Edinburgh in 2002 and 2004. The latest survey was in 2013 (Dodds *et al.*, 2014).

Furthermore, the findings from the SALSUS survey provide the prevalence rates of drinking among young people which allow community partners such as policy makers, government officers, and healthcare providers to make general use of the data for local needs assessments and to develop strategic priorities. As the purpose of the SALSUS was to monitor adolescents' drinking behaviour to provide a national picture, this made it suitable for my study. I therefore adapted the SALSUS survey to study the adolescents in Petchaburi Province, and then used my findings to work with the community to explore strategies to control young people's drinking in the community.

Because the SALSUS questionnaire had been developed for students at schools in Scotland, it was not initially fully applicable for Thai students. I had to read through the questions in the questionnaire carefully and then modify some parts of the SALSUS questionnaire to make it applicable to Thai students in terms of norms, culture, and educational level. Moreover, many articles and journals show that family background and school performance affect young people's drinking (Assanangkornchai *et al.*, 2010, Assanangkornchai, Mukthong, and Intanont, 2009). Furthermore, some journals mentioned relatively more negative consequences of young people's drinking than the SALSUS presented (Assanangkornchai, Mukthong, and Intanont, 2009). On another point, the SALSUS questionnaire did not ask about the causes of drinking which I considered was very important data for reflection with community partners in order to develop an intervention programme. Hence, I added this and other questions arising from my literature review to my questionnaire about age, religion, Grade Point Average (GPA), monthly expenditure, monthly family income, family relationships, living arrangements, causes and consequences of drinking.

My modified questionnaire consisted of eight categories, with each part being designed to elicit different information from the participants (See more details in Appendix A).

Questions specifically asked about the background of the informants and the behaviour and attitude of students toward drinking alcohol which added to the general information about their current alcohol consumption behaviour. The following shows the categories of questions which were used for asking participants about their own drinking characteristics and backgrounds.

Part I: Demographic data and family members' drinking

Part II: Questions about how often you drink

Part III: Questions about what you drink

Part IV: Questions about the effects of drinking

Part V: Questions about where you drink and with whom

Part VI: Questions about buying alcohol

Part VII: Questions about drinking and your family attitude

Part VIII: Questions about why you drink

I now describe each category in turn.

### *Part I: Demographic data*

All respondents were asked to indicate their demographic data which were important to identify the general information about the respondents' characteristics needed in this study. Moreover, the literature review indicated that demographic data such as sex (gender), GPA, monthly expenditure, relationship with family members, and living arrangements related to drinking alcohol by young people (Assanangkornchai *et al.*, 2010, Assanangkornchai, Mukthong, and Intanont, 2009; Chaveepojnkamjorn and Pichainarong, 2007; Plant and Plant, 2001). In this study demographic information included sex (gender), age, school year, GPA, monthly expenditure, monthly family income, relationship with family members, living arrangements, what students wanted to do after graduation, and family members' drinking behaviour. The question about

‘Sex’ was in a basic male-female format. The questions about ‘Age’, ‘Monthly Expenditure’, and ‘Monthly Family Income’ were collected as open-ended questions. The other questions were set out in multiple-choice format. The participants had to select one or more answers from the box or fill in the blank according to the instructions that came with each question.

*Example question:*

What school year are you in?

- ☐ 1. Matthayomsuksa 4
- ☐ 2. Matthayomsuksa 5
- ☐ 3. Matthayomsuksa 6

## *Part II: Questions about how often you drink*

There were 4 questions in this part. The participants were asked to think about their behaviour during the previous 30 days, a period which is defined as ‘current drinking’ for Thai students. Many studies of young people and alcohol consumption in Thailand have always asked for information about the previous 30 days (Assanangkornchai, Mukthong, and Intanont, 2009; Chaveepojnkamjorn and Pichainarong, 2007; Samangsri *et al.*, 2010) and to report how often and on which day they drank alcohol. Answers to the questions were given by selecting from the multiple-choice possibilities provided.

*Example question:*

How often do you USUALLY have an alcoholic drink?

(Please cross box which closely represents your answer)

- ☐ 1. Every day
- ☐ 2. Twice a week






- ☐ 3. Once a week
- ☐ 4. Once a fortnight
- ☐ 5. Once a month
- ☐ 6. A few times a year

### *Part III: Questions about what you drink*

The respondents were asked 14 questions about their drinking behaviour, namely, what types of alcohol and how much they had drunk during the previous 30 days. They had to choose their answer from multiple choices and fill in the number of glasses or bottles in the blanks.

#### *Example question:*

Write in the boxes below the number of pints, half pints, large cans, small cans and bottles of BEER, LAGER and CIDER drunk in the last 30 days.

<input type="text"/>	Pints	
<input type="text"/>	Half pints	
<input type="text"/>	Large cans	
<input type="text"/>	Small cans	
<input type="text"/>	Bottles	

- ☐ 99. Not relevant for me

### *Part IV: Questions about the effects of drinking*

There were six questions in Part IV. The informants were asked to think about the effects from drinking alcohol during the previous 30 days. The first three questions were designed to be answered by making dichotomous choices: 'Yes' or 'No'. The following question is an example:

*Example question:*

Have you been drunk in the last 30 days?

☐ 1. Yes

☐ 2. No

The other questions were multiple choice; in the sixth question there were nineteen sub-items that had to be answered by giving ratings for the results. These response rating categories were 'Never', 'Sometimes' and 'Often'. In this part, there is a question of students who drink '*five or more drinks on the same occasion*'. '*Five or more drinks on the same occasion*' is defined as 'binge drinking' (Department of Health and Human service, 2011; National Advisory Council, 2004).

*Example question:*

In the past year, as a result of drinking alcohol have you ...?

(Please cross ONE box on EACH LINE)

Results	1=Never	2=Sometimes	3=Often
R1. Had an argument			
R2. Had a fight, violent event, assaulted			

*Part V: Questions about where you drink and with whom*

The participants were asked to answer three questions about the places they had preferred to drink during the previous 30 days by selecting answers from the choices provided. The exception was the second question which asked how often the participants drank alcohol with their family members, and the participants then had to give the frequency with which they drank with these people. The response categories were 'Never', 'Rarely', 'Sometimes', 'Often' and 'Haven't seen or don't see this person'.

*Example question:*

When you drink alcohol, how often are you with the following people?

(Please cross ONE box in EACH LINE)

People	1=Never	2=Rarely	3=Sometimes	4=Often	5=Don't have or don't see this person
W1. Mother					
W2. Father					

*Part VI: Questions about buying alcohol*

In this part, there were five questions, in which the participants were asked to think about the places where they bought alcohol and how much they had spent on alcohol during the previous 30 days. They had to select the answers from the multiple choices provided.

*Example question:*

If you buy alcohol, where do you USUALLY buy it?

(Please cross only ONE box)

- ☐ 1. I never buy alcohol
- ☐ 2. In a pub or bar
- ☐ 3. In a club or disco
- ☐ 4. From an off-licence
- ☐ 5. From a shop
- ☐ 6. From a supermarket



- ☐ 7. From a friend/relative
- ☐ 8. From someone else (Please write in) .....
- ☐ 9. From somewhere else Please write in) .....
- ☐ 99. Not relevant for me

### *Part VII: Questions about drinking and your family*

The participants were asked three questions about their family members' attitudes towards their drinking. They had to select their answers from the multiple choices given.

#### *Example question:*

How does your family feel about you drinking alcohol?

(Please cross only ONE box)

- ☐ 1. They don't like it
- ☐ 2. They don't mind
- ☐ 3. They don't know I drink alcohol
- ☐ 4. I don't know
- ☐ 99. Not for me

### *Part VIII: Questions about why you drink*

There was only one question in this part but there were eleven sub-items. The informants were asked to think about the causes of their drinking and to select their answers from the choices provided. However, they could choose more than one answer, if it was applicable to them.

*Example question:*

What are the causes of your drinking?

(You can cross MORE THAN ONE box if this applies to you)

- ☐ 1. Relatives drinking: father, mother, sibling
- ☐ 2. Peer pressure, peer drinking, in a gang
- ☐ 3. Tension Reduction: broken heart, grief and loss, loneliness etc.
- ☐ 4. Attitude toward alcohol use: supportive attitude toward alcohol use, acting like a man, enjoyment
- ☐ 5. Perceived susceptibility of alcohol use
- ☐ 6. Perceived self-efficacy
- ☐ 7. Accessibility of alcohol around university
- ☐ 8. Accessibility of alcohol around community
- ☐ 9. Exposure to anti-alcohol campaign
- ☐ 10. Exposure to alcohol advertising
- ☐ 11. Benefit: it's good for health
- ☐ 99. Not for me

## **4.5 Validity and reliability**

### **4.5.1 Content validity**

In section 4.4 I present the questionnaire used in this study modified from SALSUS (Black *et al.*, 2008) which had originally been designed to collect data from students in Scotland. This means that it had to be suitably modified for use with Thai students in terms of norms, culture, educational level, and findings from previous studies which were explained in Chapter Two. After that, the questionnaire was given content validation by my supervisors and the professor of clinical psychology in the

university's School of Health in Social Sciences. After their initial approval of the questionnaire, I once more revised the questions to achieve greater clarity and the questionnaire was then sent to my supervisors for a second proofreading.

When I had finished this process, I then translated the questionnaire from English into the Thai language and sent it to experts in Thailand. The study tool was reviewed at a panel meeting of Thai experts, consisting of the director of the nursing school, a psychiatric nurse lecturer, and a children's health nursing specialist. The experts thoroughly considered and then approved the questions one by one, assessing the linguistics, the meaning, and the arrangement of the various questionnaire items. The Thai version of this research tool was then edited again, clarifying meanings by using easier words, ensuring that every item corresponded to the measurement sought and that everything that should be measured was actually measured, thus facilitating students' understanding and smooth answering of the questions. Before collecting data, I sent this questionnaire again to the director of Petchaburi Secondary Education Service Area Office 10 for approving its contents, details of questions, and the suitability of the linguistics for the secondary school students. After only one week, the director called me back and allowed me to use this questionnaire for data collection.

#### **4.5.2 Pilot study**

As described in section 4.5.1, the questionnaire was reviewed by experts in the School of Health in Social Science at The University of Edinburgh, and experts in Thailand: the director of the nursing school, a psychiatric nurse lecturer, a children's health nursing specialist, and the director of Petchaburi Secondary Education Service Area Office 10. It was also discussed with a school principal and advisory teacher before the pilot study. The school principal and advisory teacher made more suggestions, enabling the study tool to be clearer and more effective in collecting data from the students, for example, they suggested putting a number on the questionnaire for checking the return rate, and to strictly describe the instruction with the questions when choosing more than one option. Moreover, they suggested that the completed

questionnaires should be directly returned to the research team and should not be passed from student to student, in order to protect anonymity.

The questionnaire was then piloted with 30 secondary school students in one school in Petchaburi Province, where the students had the same characteristics as the samples but were deliberately not in one of the sample units. This trial test aimed to clarify the questionnaire and test its reliability with the students. The samples in the trial process were from Matthayomsuksa 4, 5, and 6. The research assistant personally delivered the questionnaire to the students. The roles of research assistants are described in Section 4.6.2.

I gave instructions for completion of the questionnaire, and information about the various alcohol types with a PowerPoint presentation. I then gave students the opportunity to ask questions prior to completing the questionnaire. Following this exercise, several questions were reworded to provide clarity and the order of questions was altered to facilitate understanding and flow. Generally, students said they had been able to clearly understand the questionnaire and to answer it easily.

## **4.6 Data collection**

### **4.6.1 The data collection process**

The fieldwork for this survey was conducted from October 2011 to January 2012. The self-report questionnaires were collected from 845 secondary students in eight schools. In this section I describe the process of gaining informed consent, and of data collection.

#### *Gaining Access*

Two weeks before the data collection, I met with the advisory teachers in each school. The advisory teacher is an important person to enable students to decide whether to participate in my study because he/she has a good relationship with students and helps students to resolve their problems when they are at school. Normally, the advisory teacher has a duty to look after students in school and act as a counsellor. I explained

the details of the research procedure, and then I left consent forms and information sheets for the students' parents or guardians so that they would be aware of the study and be able to make a decision whether or not to allow their children to participate in the study. At the same time, I left my contact telephone number with the advisory teachers in case they wanted more information or wanted to ask any questions. After meeting with the advisory teachers, a timetable for data collection was set. The ethical considerations, including the gaining of informed consent, is discussed in Section 4.8.



**Figure 4.4 The environment of data collection process**

I allowed three days before collecting data for students to return the consent form. Therefore, the students' parents or guardians had a lot of time to read and understand the consent form. Parents or guardians did not have to agree immediately when their children first broached the subject with them. They could ask questions of the advisory teacher or me, or come to school and discuss with the school principal and school teachers so that they felt confident in deciding whether to allow their children to participate in the study. Even if parental consent was given, students themselves could decide that they did not wish to take part in this research. Students who did not want to participate in the survey were assured that this would not in any way affect their future studies at the school. They would still have all the benefits that they would otherwise be provided with by the school. This information was re-introduced to students by the advisory teachers before the data collection process started.

### *Collecting Data*

Data collection was supported by a research team comprising staff from a nursing college in Petchaburi Province. All the students in the selected classes were asked to complete the self-administered questionnaire during a regular class period. The research team gave assurance that the results would be reported only in a group format. The questionnaire took about 40–50 minutes to complete.

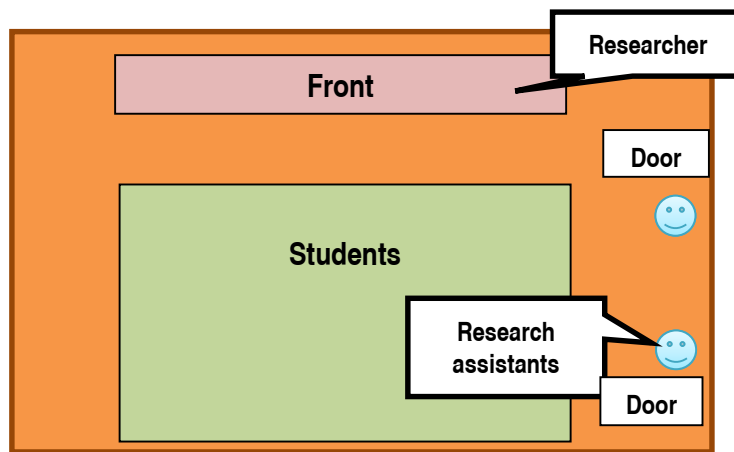
On the day of data collection, the research team collected all signed informed consent forms and checked for giving permission for the students to participate in the study. In my study there was no student who refused to complete the questionnaire. I gave a detailed explanation of the study, and then the research assistants walked around the class providing questionnaires and pens to students.

I then explained how to fill in the questionnaire and presented “Types of Alcohol” (Figure 4.5) and gave them a chance to clarify their understanding of any questions before tackling the questionnaire. While completing the questionnaire if students had any problems or queries, they raised their hands and the research team walked to each desk to help them to clarify queries. When the students had finished answering all the questions, they put the questionnaire in an envelope. Then they walked to me or the research assistants who stood near the door. The research team collected the envelopes, and then allowed the students to leave the classroom.



**Figure 4.5 Power point presentation: ‘Type of Alcohol’**

I had been concerned that walking around the classroom while students were completing the questionnaire might affect answering the questions. For example, in one school when the school teacher walked among students who were answering the questions, they immediately stopped completing the questionnaire. I went to the school teacher and requested her to wait outside the classroom. The following figure shows the position of the research team while students were completing the questionnaire.



**Figure 4.6 The position of the researcher and research assistants**

As Figure 4.6 shows I stood in front of the classroom for presenting the PowerPoint presentation and then was on standby for helping students when they had a problem. The research assistants stood near the doors for collecting questionnaires after students completed and returned to the research assistants before they left the classroom.

#### **4.6.2 Research assistants' training**

The research assistants were nurse lecturers in Prachomklao Nursing College, Petchaburi Province. I met with the research assistants to clarify my study. The purpose of my study was described and all the documents relevant to my research were explained. For example, I explained all the questions in the questionnaire and the type of alcohol to the research assistants. I also explained their roles to them to facilitate the participants such as providing questionnaires with a pen and an envelope, collecting questionnaires from participants, recording interviews (in Phase Two), taking notes, and preparing food and drink for the research team. It was important that I told them not to interrupt or pressure the participants while they were completing the questionnaire or communicating with the researcher. In total, I spent one and a half hours preparing my research assistants.

Data were not collected from all students in selected classrooms in eight schools because there were some students who were absent from school on the day of the data collection. I had to arrange another time and returned for the second time for data collection in some schools in order to ensure that my sample was representative. The

second data collection was organised by the researcher and advisory teacher who did not tell students before the collecting time in order to reduce the potential effect from students who had already completed the questionnaire. A second attempt to collect data from missing students was felt to be valid as the information sought was of an individual nature and would therefore be less amenable to the effect of discussion with peers. Unfortunately, there were still some absent students because of sickness and their Reserve Officer Training Corps commitments.

### **4.6.3 Bias reduction**

I adopted various methods to try to reduce bias. Firstly, I reviewed the existing literature to explore appropriate methodologies. I learned from the literature reviews that the research methodology needs to suit the research design. The appropriate design will make a study strong and ensure its quality. For example, if I were only to use a questionnaire in my study, I would not have been able to obtain in-depth information about stakeholders' attitudes towards the alcohol consumption behaviour of young people. Therefore I used Participatory Action Research in the second phase of my study to collect more details that could not be obtained from the questionnaire participants.

Before my study took place I regularly discussed the design and methodology with my supervisors and the professor of clinical psychology, and incorporated their feedback into my field work. Moreover, their feedback not only helped me to shape my research design but directly pointed me to the target study groups. For example, my supervisors helped me to check concepts and appropriate questions for my data collection.

Data collection for the questionnaire was organised to cover the area in Petchaburi Province where there was a variety of participants, characteristics and backgrounds. As described in Section 4.2 about the location of the study sites, there is a difference in the geographic and demographic characteristics of the samples in eight districts where I collected data. I was concerned that if I collected data in only one area, I would not be able to generalise my findings about the characteristics of young people's drinking in Petchaburi Province. For example, if I collected data only in School A



which is located in a city centre where there are plenty of pubs, bars, and alcohol shops, and young people tend to drink alcohol in high quantities, it would bias my findings if I presented these data on behalf of Petchaburi Province. It is better therefore if I collect data from eight districts and then present a more representative picture of young people's drinking in Petchaburi Province.

The questionnaire was thoroughly modified from the original SALSUS questionnaire and then used to collect data from secondary students in the eight study sites. As described above, the original SALSUS questionnaire was designed to explore adolescents' characteristics related to smoking, drinking, drug use, and leisure activities. The SALSUS directly studies adolescents which is relevant to my research which focuses on a similar population in Thailand.

## **4.7 Data analysis**

Data from participants were collected and stored in a locked cabinet and then were keyed into the Statistical Package for Social Science (SPSS) software which is the most comprehensive statistical software used for quantitative data analysis (Greasley, 2008). In my study, I used SPSS version 18. In my study, there were various data types: nominal scale e.g. sex; interval scale e.g. Grade Point Average (GPA); and ratio scale e.g. age. For the purposes of analysis, I had to consider which tests were suitable for my data. For this study, I chose to use 'Frequencies', 'Chi square test', and 'Logistic regression' to explore the findings from the survey.

### *Descriptive Statistics*

'Frequencies' is one way to display the distribution of the data, which lists the values of a variable such as sex, age, school year, GPA, monthly expenditure, family income, family member relationship, living arrangements, what students want to do after leaving school, days on which students drank alcohol, types of alcohol, how often students have been 'really' drunk<sup>10</sup>, and the effects of drinking alcohol, and the corresponding numbers and percentages of participants for each value. The output of

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<sup>10</sup> Students who got drunk after drinking alcohol and cannot control themselves

the 'Frequencies' function of SPSS provides tabulated frequency distributions for each variable expressed as a percentage of the sample (Field, 2000).

### *Chi Square*

The 'Cross-tabulation' (Chi square test) is displayed in Chapter Five, examining the association among the categorical variables in greater detail than simple frequencies for individual variables (Greasley, 2008). It cross-tabulates the data to identify more specific information about the association between the two variables. The crosstabs command tabulates the data and then carries out numerous statistical tests to see whether the variables are associated (Field, 2000). For my study I investigated the association between young people's drinking behaviour and demographic information, data relating to family members' drinking, students' drinking patterns, sources of buying alcohol, and family attitude. These correlations were examined on the basis of the findings of the literature review.

### *Logistic Regression*

The purpose of using logistic regression was to select one school for conducting Participatory Action Research in phase two. Logistic regression is a form of multiple regression but with an outcome variable that has a categorical dichotomy and predictor variables that are continuous or categorical (Burns and Burns, 2008). It is used to analyse data when there are only two categories of the dependent variable (dichotomous variables) including procedures by SPSS for generating the necessary dummy (nominal scale) variables automatically, and is more statistically robust.

For my study, a logistic regression model was used to explore which students and environmental characteristics were associated with drinking alcohol in the previous 30 days. The model identifies associations/factors which identify students with an increased or decreased risk of drinking alcohol during that period. The variations in risk are expressed as odds ratios and showed the relation to a reference category, which is given a value of 1. Odds ratios greater than 1 indicate higher odds (increased risk), and odds ratios less than 1 indicate lower odds (reduced risk) (Kim and Mallory, 2014), also shown are 95% confidence intervals for the odds ratio. Where the interval does

not include 1, this category is significantly different from the reference category. Full details of the logistic regression are contained in Chapter 5.

## **4.8 Ethical considerations**

Polit and Beck (2004) noted that ethical consideration is required at every level of the research process in order to protect the rights of participants. The International Council of Nurses (ICN, 2006) and the American Nurses' Association (ANA, 2010) have developed ethical principles to guard patients from harm and to protect participants in research. In my study I was concerned about any ethical issues that might arise among participants during each phase of the study. Here I discuss the ethical issues associated with conducting the survey.

I applied for ethical permission from the Research Ethics Committee of the School of Health in Social Science (SHSS). I sought Level 2 permission as this was necessary for my study as it had young people and local stakeholders as participants (Appendix B). The proposal was reviewed and approved by the Subject Research Ethics Team/Co-ordinator, the School of Health in Social Sciences, The University of Edinburgh, and then the proposal was translated into Thai language and approved by the Ethics Review Committee of Petchaburi Secondary Education Service Area Office 10 (Appendix C).

### **4.8.1 Anonymity**

Participants have the right to privacy (Polit and Beck, 2004) which can be invaded during any study and which includes maintaining confidentiality and anonymity of data (Hutchison and Wilson, 1994). I aimed to respect the rights and dignity of participants by strictly avoiding disclosure of any of their personal information in terms of the protection of their personal and sensitive data under the UK Data Protection Act (1998). Personal information such as the students' full names, the institution's names, the home addresses and contact details were not listed in the research. Questionnaires were numbered in order to protect participant identity and anonymity. The code number only tells the total amount of the questionnaires and does

not link to students' personal information. Data were collected by myself and research assistants and kept securely in a locked cabinet that only I can access.

#### **4.8.2 Voluntary participation**

As a researcher I was aware of the issue of voluntary participation and the obligation to protect participants from coercion. Researchers' behaviour must be ethical all times (Parahoo, 2014). During data collection it was vital to be sensitive and to respect participants' feelings, values and personal beliefs. I notified the participants in advance about the topic, objectives, benefits and potential risks of this research project (Polit and Beck, 2004). Only those participants who agreed to give information to me were asked to do the survey and they were given clear details of the procedures involved and I employed only specific codes for recording the information. Participation was voluntary and anonymous. The participants' responses were confidential to the research team. Participants were able to refuse to answer questions at any time if they felt uncomfortable and without affecting their studies. In fact in my study there was nobody who refused to complete the questionnaire and because of the anonymous nature of the data there was no opportunity to withdraw.

#### **4.8.3 Informed consent**

My survey studied young people who were aged under 20. It is important to think about informed consent (as discussed in Section 4.6.1) because students cannot sign the form themselves as they are below the age of consent in Thailand. It was necessary therefore to get permission from the young people's parents/guardians. The purpose of informed consent is to ensure that people are not coerced and are not fooled into participating in something when they do not know what they are getting into. I am fully aware of the ethical requirements when undertaking research with young people, and all research participants. The detail of informed consent form can be seen in Appendix D.

It was made clear in the information sheet that participation was voluntary. Because the students were underage, they could not sign the consent form themselves. Instead

their parents or guardians were the ones who decided whether to allow the students to participate in the study or not. In this case, parents could contact me or the advisory teacher to discuss the study prior to consenting for their children as described in Section 4.6.1, including how the consent process for parents' illiteracy was dealt with.

In the case of illiteracy, parents could find a witness who accurately read the consent form to the participants, and the consent form was signed by a literate witness chosen by the parents or guardians. This witness had no connection to the research team. In addition it was important that parents or guardians included their thumb print on the consent form.

## **4.9 Conclusions**

This survey was the first phase in my research and was an essential step to identifying the alcohol consumption behaviour of Thai adolescents. This chapter has provided more details on how the survey was conducted, exploring the characteristics of alcohol consumption by young people in Petchaburi Province.

The 845 participants were all secondary school students who had been selected from eight schools by using a multi-sampling technique. The questionnaire in this study was modified from the SALSUS questionnaire, which had originally been used for surveying the lifestyle and substance use of adolescents in Scotland. This study tool was validated and piloted with students in one school.

The data collection process began in October 2011 and finished in January 2012. I collected data twice at each school because there was a problem with absent students who were sick or had had ROTCS (cadet training). During the process of the survey, I controlled bias by using various methods such as research team training, discussion with supervisors, and I collected data to cover all regions of the study site. Finally, the data were analysed using the SPSS software. Ethical considerations were paramount in this study because it was carried out with participants who are considered a vulnerable group as they were not aged over 20 years (the age of legal consent in Thailand). A consent form was provided for students' parents or guardians to sign, allowing their children to participate in the study, and the participants themselves also

had the right to refuse to answer any questions. The information was anonymous and confidential to which only the researcher had access.

This survey was the first step in the Action Research cycle, an essential step in which to identify alcohol consumption behaviour of Thai adolescents.

The next chapter will present the findings from the survey with graphs, tables and discussion which will assist readers to clearly understand the first phase of my study and link the findings to the second phase.

## **Chapter 5**

### **Findings: Survey study**

#### **5.1 Introduction**

The previous chapter gave a detailed account of the approach and research design in this study. This chapter presents the findings of the survey study completed by students from eight schools. The students were between 15 and 19 years old and currently studying in Matthayomsuksa 4, 5 and 6. The modified questionnaire is shown in Section 4.4 and the full questionnaire in Appendix A. The purpose of this phase of the research was to investigate the young people's attitudes and behaviour regarding drinking alcohol.

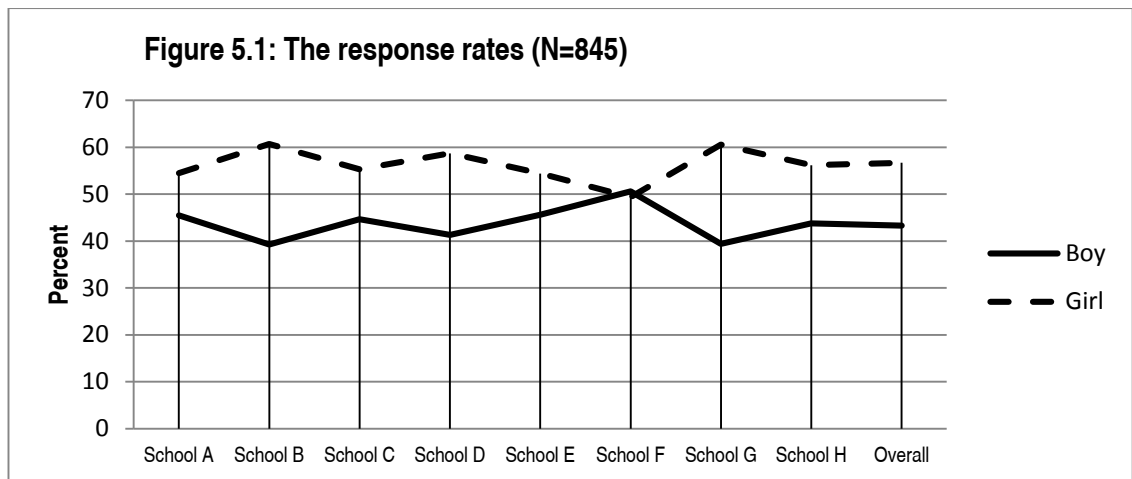
I have divided this chapter into three parts. Part One presents the findings in graph designs. The information includes the response rates, demographic data, a description of students' family members and alcohol related behaviour, the prevalence and characteristics of alcohol consumption by students in Petchaburi Province, sources of buying alcohol, family attitudes to young people's drinking, and causes of young people's drinking.

In Part Two, I present my analysis, exploring the association of these factors and young people's drinking behaviour. The findings will be shown in cross-tabulation tables. Finally in Part Three I will present how I selected one school for undertaking Participatory Action Research using a focus group and in-depth interviews. The logistic regression method was used to analyse data from eight schools to choose the appropriate school for the second phase of my study.

#### **Part One: Findings of the survey study**

#### **5.2 Response rates**

The survey questionnaire was completed by secondary school students who were studying in Petchaburi Province. Figure 5.1 shows the response rates for each school.



In total, eight schools from the 24 sampled classes took part in the survey. Overall 845 students from the target sample of 902 completed the questionnaire. The overall response rate was 93.68%. Figure 5.1 presents the response rate by school and gender. The figure shows that a majority of the respondents in each school were girls except School F where the proportion of boys and girls is almost equal (50.6% of boys and 49.4 of girls). Overall, the proportion of girls who responded was 56.7%, compared with 43.3% of boys.

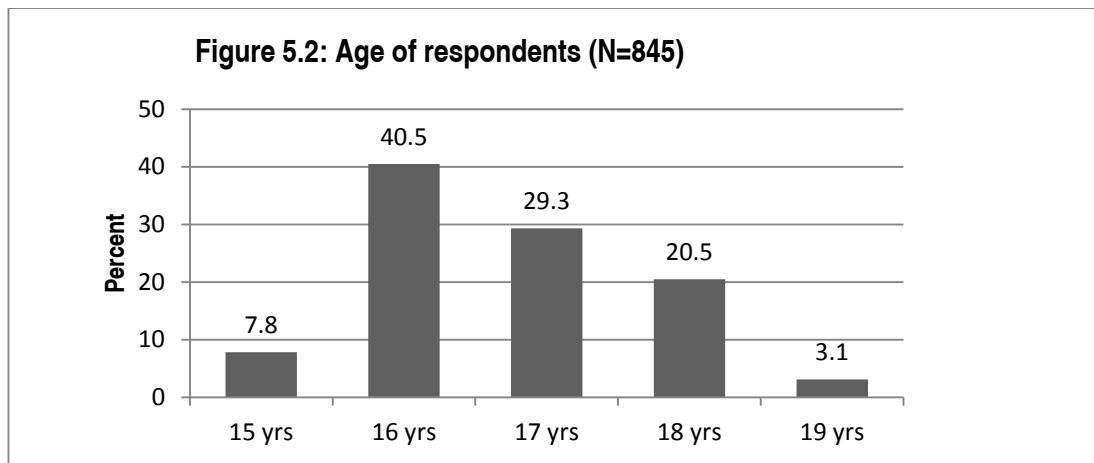
### 5.3 Demographic data and family members' drinking

This section presents demographic data including age of the participants who completed questionnaires, grade point average (GPA), their monthly expenditure, family income, relationships with family member, and living arrangements.

#### 5.3.1 Age of students

Students were asked 'how old are you?' The data are presented in Figure 5.2. The following figure shows the results.

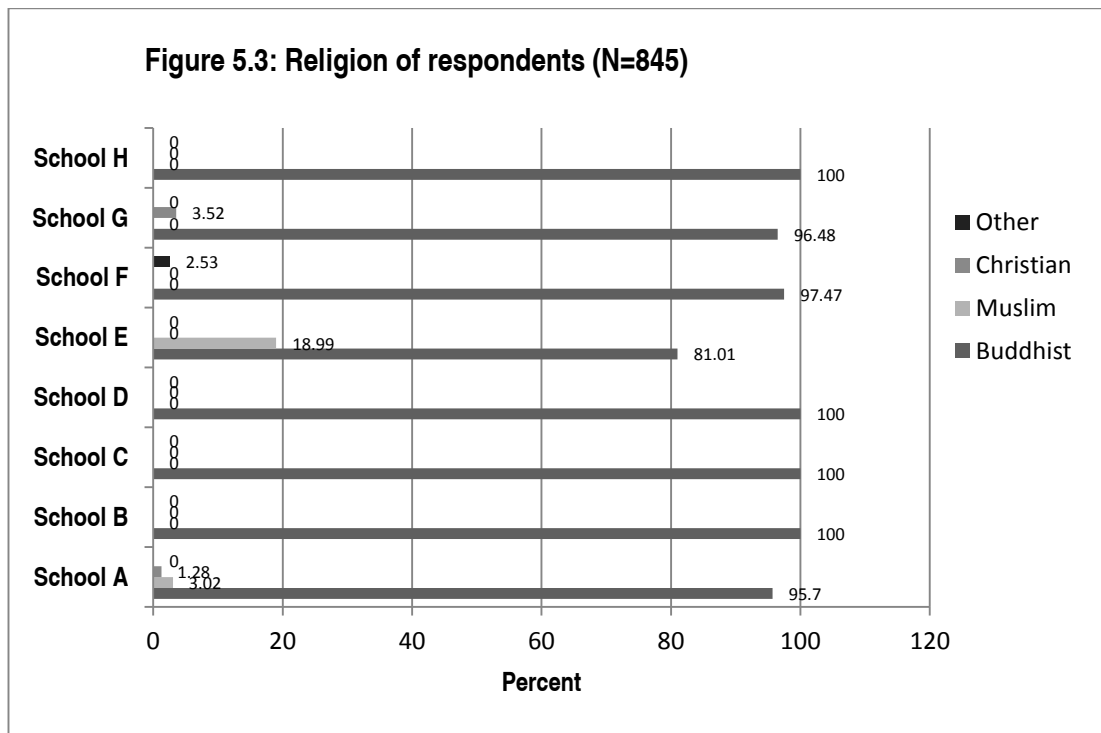




The age range of students who completed the questionnaire was 15 to 19 years. The largest proportion of participants in this survey comprised students aged 16 years (40.5%). The youngest students were 15 years (7.8%) and the oldest were aged 19 years (3.1%).

### 5.3.2 Religion

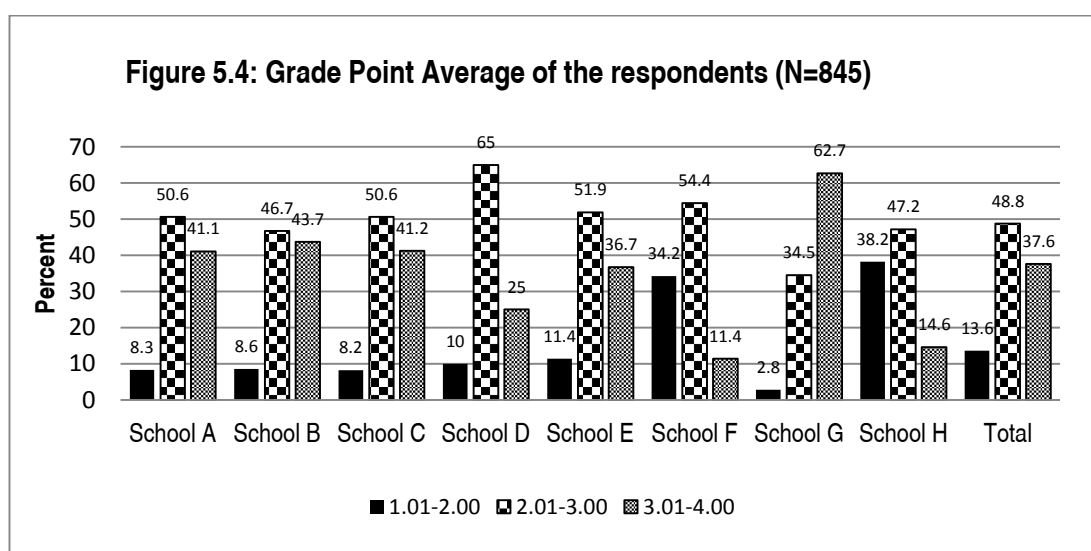
Students who completed the questionnaire were asked about their religion. The figure 5.3 shows the information of students' religion.



The findings show that most students who completed the questionnaire were Buddhist. This was a hundred percent of students in School B, School C, School D, and School H. School E students said they were Muslim (18.99% of students). There were two schools out of eight schools where students reported that they were Christian (1.28% of students in School A and 3.52% in School G). Only School F reported 2.53% of informants who believed in Ancestor Ghosts. These students are from hill tribe people and they respect their grandparents. When their grandparents pass away, they believe that the spirit of their grandparents will protect them.

### 5.3.3 Students' Grade Point Average (GPA)

Figure 5.4 shows the information about students' grade point average.

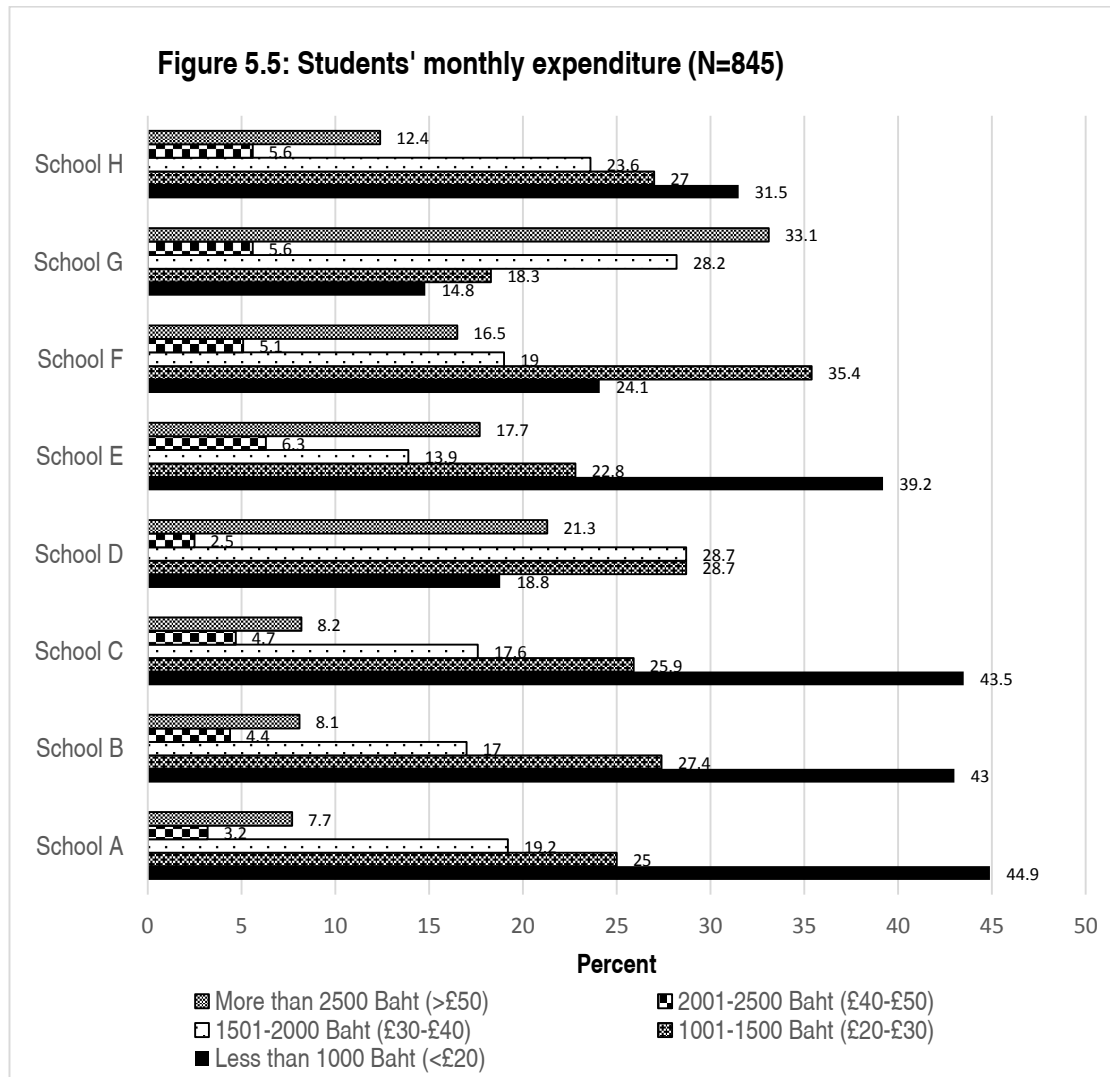


In Thailand the GPA is grouped into four ranges: 0.01-1.00, 1.01-2.00, 2.01-3.00 and 3.01- 4.00. Because nobody completed the questionnaire giving a GPA below 1.00, I have categorized the GPA into three ranges of 1.01-2.00, 2.01-3.00 and 3.01-400.

The information from Figure 5.3 shows the GPA of respondents from eight schools. The greatest proportion of students with a GPA in the 2.01-3.00 range was reported by students in all schools except students in School G who reported the greatest proportion in the 3.01-400 range. The smallest proportion of students reported a GPA in the 1.01-2.00 range. However, students in School F and School H were likely to report a GPA in this range more than the other schools.

### 5.3.4 Students' monthly expenditure

The students were asked 'how much is your monthly expenditure?'.

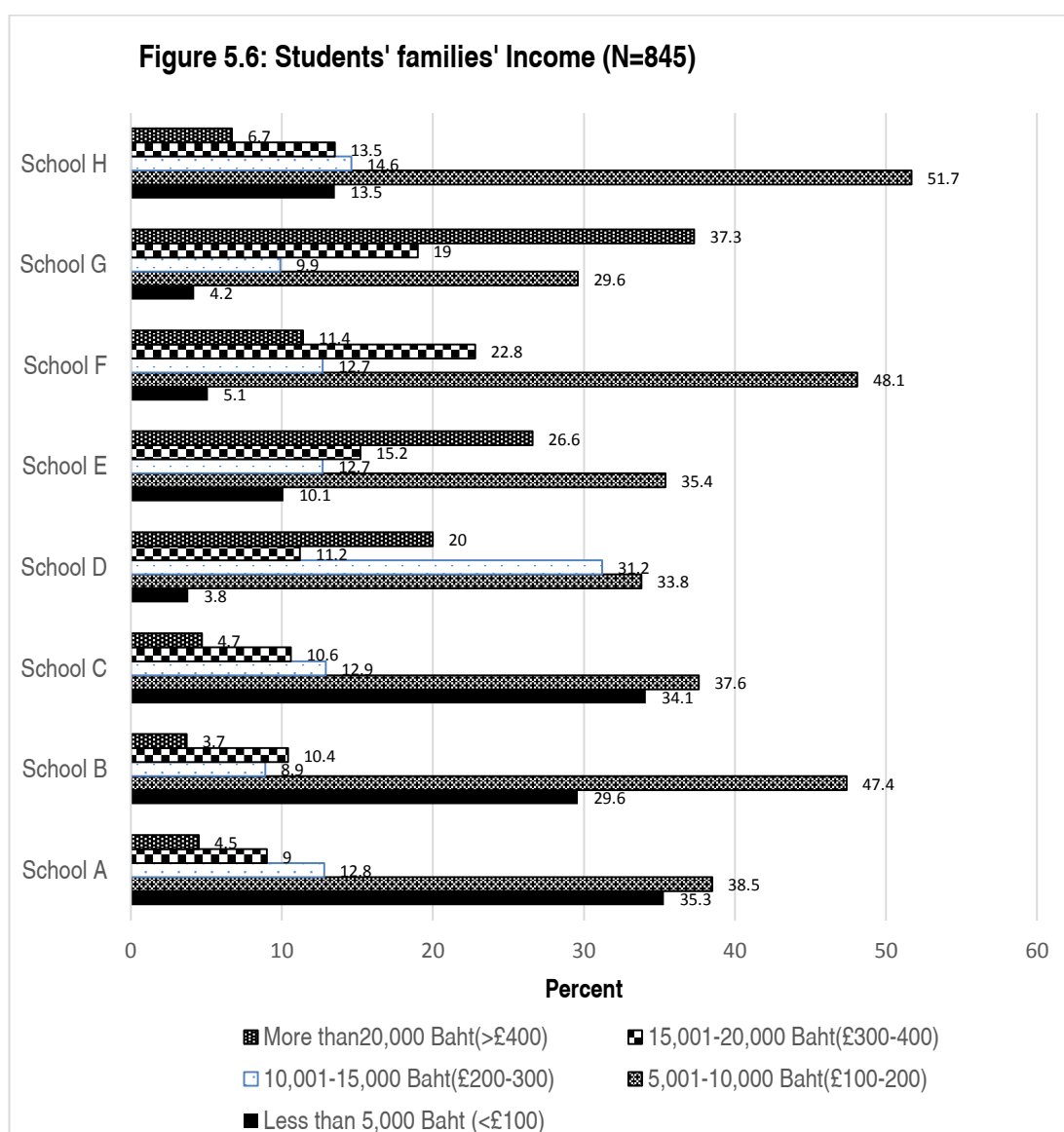


The findings show that most students reported that their monthly expenditure was less than 1,000 Baht (<£20) which is lower than the average monthly expenditure reported by the Ramajitti Institute's study (Ramajitti Institute, 2010) which studied the monthly expenditure of secondary students in Thailand in 2010. According to that study, the average monthly expenditure of secondary school students was reported as 2000 Baht (£40), an average of 70 Baht (£1.50) a day. In my study most students in School G reported that their monthly expenditure was more than the average expenditure. This information can be interpreted alongside the information in Section 5.3.5 which shows

that students' family income in School G was very high, and Section 5.3.7 which reported that some of the students in School G live in privately rented dormitories in the surrounding areas of the school.

### 5.3.5 Students' families' monthly income

Respondents were asked 'how much is your family's income?'.



The findings show that most students in this study reported that their family's monthly income was 5,001-10,000 Baht (£100-£200) which is similar to Rose's report where 9,000 Baht was presented as the average monthly income in Thailand (Rose, 2012).

On the other hand, most students in School G were more likely to report that their family's monthly income was more than the Thailand average salary income. Referring to Chapter One, Section 1.4, School G is described as close to a famous seaside resort where there are many tourists. People in this area can earn a great deal of money from tourism such as from restaurants, clothing and souvenir businesses. Moreover, this finding relates to the finding in Section 5.3.4 which showed that students spent more money in a month than the average expenditure and some of them lived in private dormitories as described in Section 5.3.7.

### 5.3.6 Family member relationships

In this section, students were asked 'how good are your relationships with family members?'

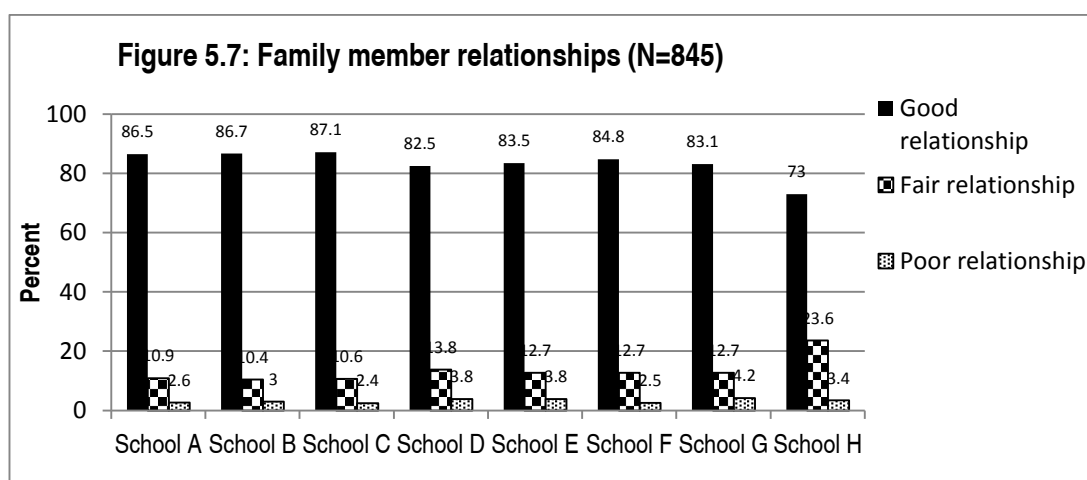


Figure 5.7 shows that most students (83.8%) reported a 'Good relationship'<sup>11</sup> with their family member while 'Fair relationship' was represented in 13%, and 'Poor relationship' was the least reported proportion (3.2%). More than 80% of students in each school presented their family member relationships as 'good' except students in School H where the percentage dropped to 73%.

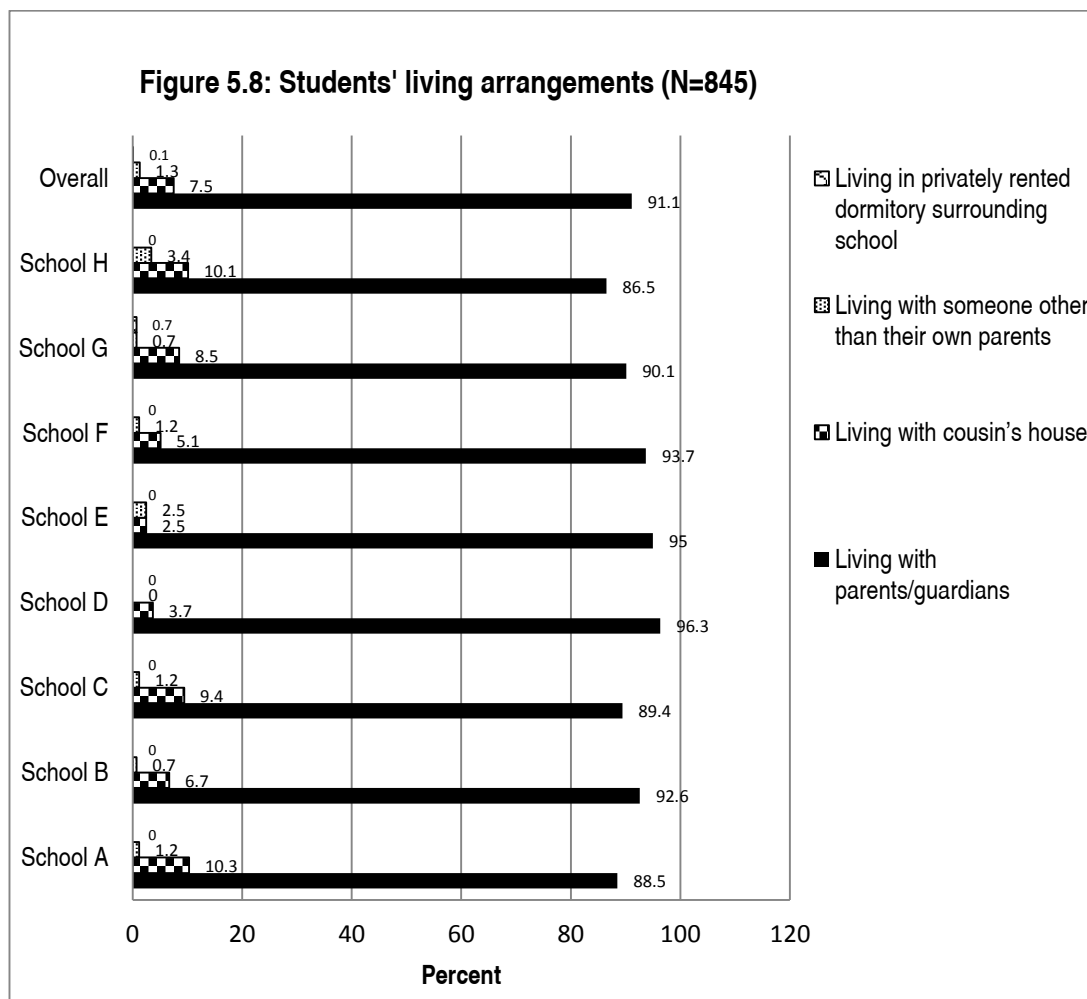
<sup>11</sup> Good relationship means there are no argument between family members

Fair relationship means there are sometimes arguments between family members

Poor relationship means family members often have arguments in family

### 5.3.7 Students' living arrangements

Students were asked 'what is your living arrangement?'. The following figure shows the finding from students who completed the questionnaire.



Most students (91.1%) reported that their living arrangement was 'Living with parents/guardians' while a small proportion of them reported 'Living in a cousin's house' (7.5%), 'Living with someone other than their own parents' (1.3%), and 'Living in privately rented dormitory surrounding school' (0.1%). For all schools, students reported similar living situations, except students in School G where a few students said that they lived in privately rented dormitories in the surrounding areas of their school (0.7%). According to the findings presented in Section 5.3.5, having a high family income appeared to give parents the flexibility to allow their children to live away from home in private flats and close to their schools. This finding revealed that

some students in School G had a higher monthly expenditure than students in the other schools.

### 5.3.8 What do students want to do after leaving school?

The students were asked ‘which one of these activities do you think you want to be doing when you leave school?’

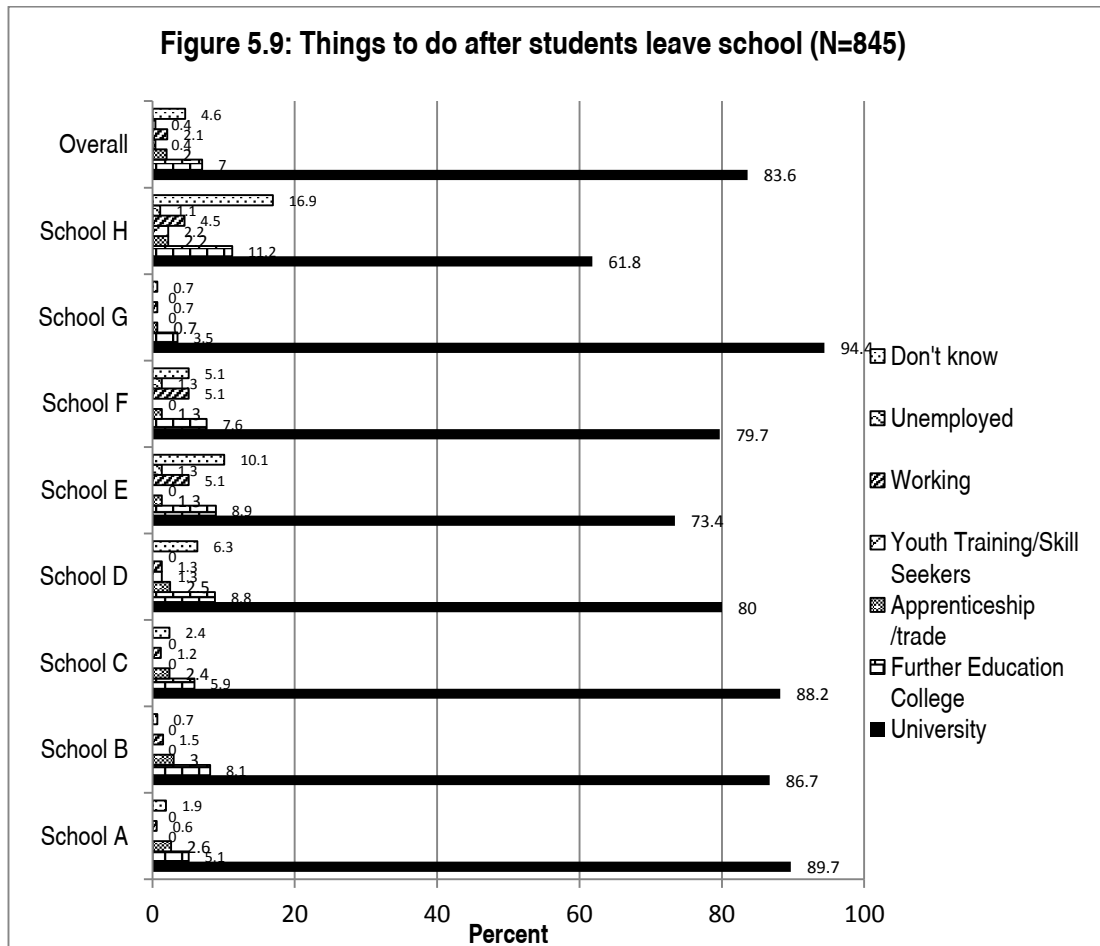


Figure 5.9 shows overall that most students who completed the questionnaire (83.6%) reported that they wanted to continue to study in universities. A small proportion of students reported that they wanted to do ‘further study in college’ (7.0%), followed by ‘go to an apprenticeship or trade’ (2.0%), ‘go to work’ (2.1%). They were least likely to want to go to ‘youth training/skill seeker’ or be ‘unemployed’ with the same proportion of 0.4%. In this section, there were 4.6% of students who did not know what they wanted to do after leaving school.

The information from Figure 5.9 shows that most respondents (83.6%) wanted to study at university after leaving school. In this case the lowest proportion of students were in School H. Section 1.6 in Chapter One indicates that School H is close to the Thailand – Myanmar border and about 65 kilometres from the city centre where the university is located, which suggests that students are less likely to be able to study there because transport is difficult. On the other hand, the greatest proportion of students who reported that they wanted to study in university were in School G. This school is near the highway which is convenient for public transportation. At the same time, this finding is supported by the information in Figure 5.3.5 which shows that the greatest proportion of students who reported that their family income could support them for further study in university were in School G. The other options showed lower proportions; in this case, ‘further education in college’ is interesting to note. Some students in each school reported that they wanted to study in further education college which is easier than going to university. These are vocational colleges and there is one in each district so that students can apply to study there in their own district when they leave school.

The next section presents information about family members who have drunk alcohol, the frequency of family members’ drinking, and family members who have been drunk.

### **5.3.9 Family members who have drunk alcohol**

Students were asked ‘do you have some family member who has drunk alcohol?’ The following figure shows information on how students answered this question.



**Figure 5.10: Family members who have drunk alcohol (N=845)**

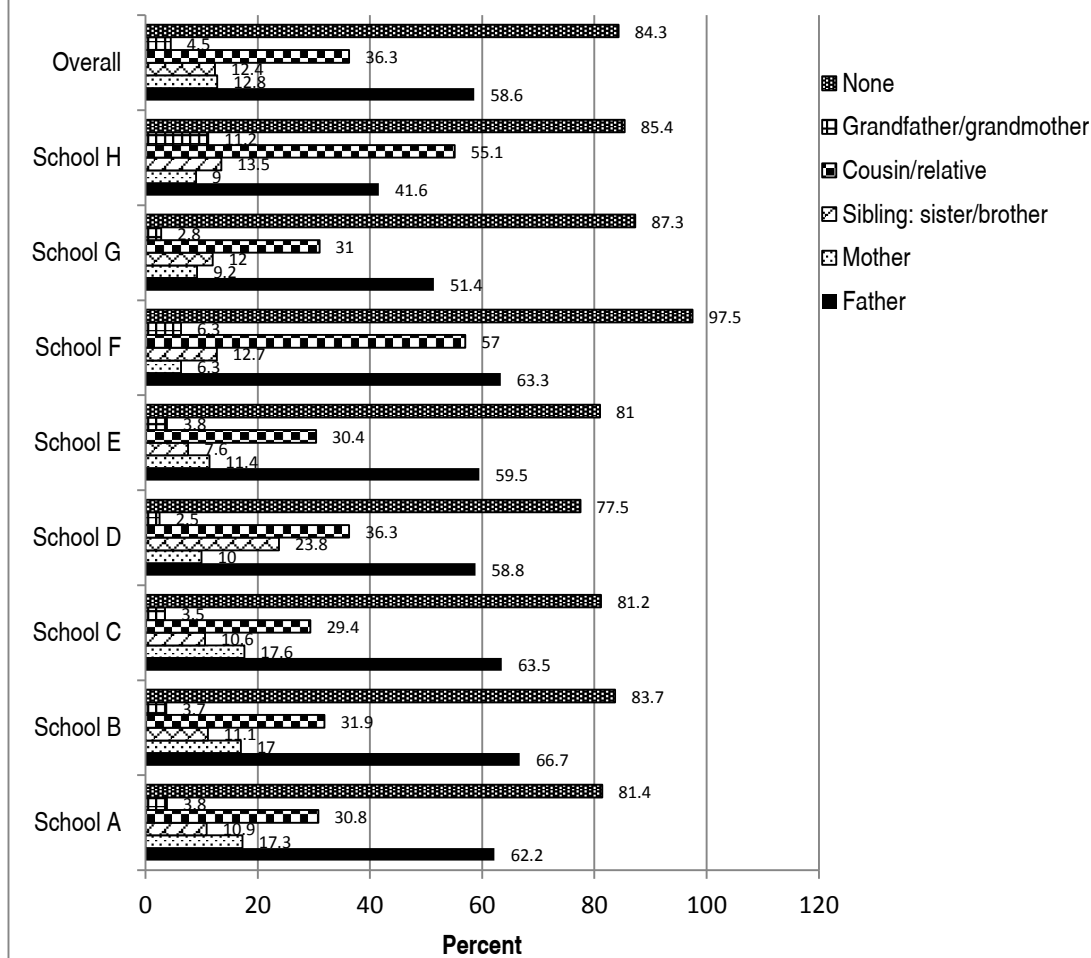


Figure 5.10 shows that most students (58.6%) said that their fathers had drunk alcohol while 36.3% reported that their cousins/relatives had drunk alcohol. There was an equal proportion between mothers and siblings who had drunk alcohol (12.8% compared with 12.4%). The least proportion was grandfather or grandmother (4.5%).

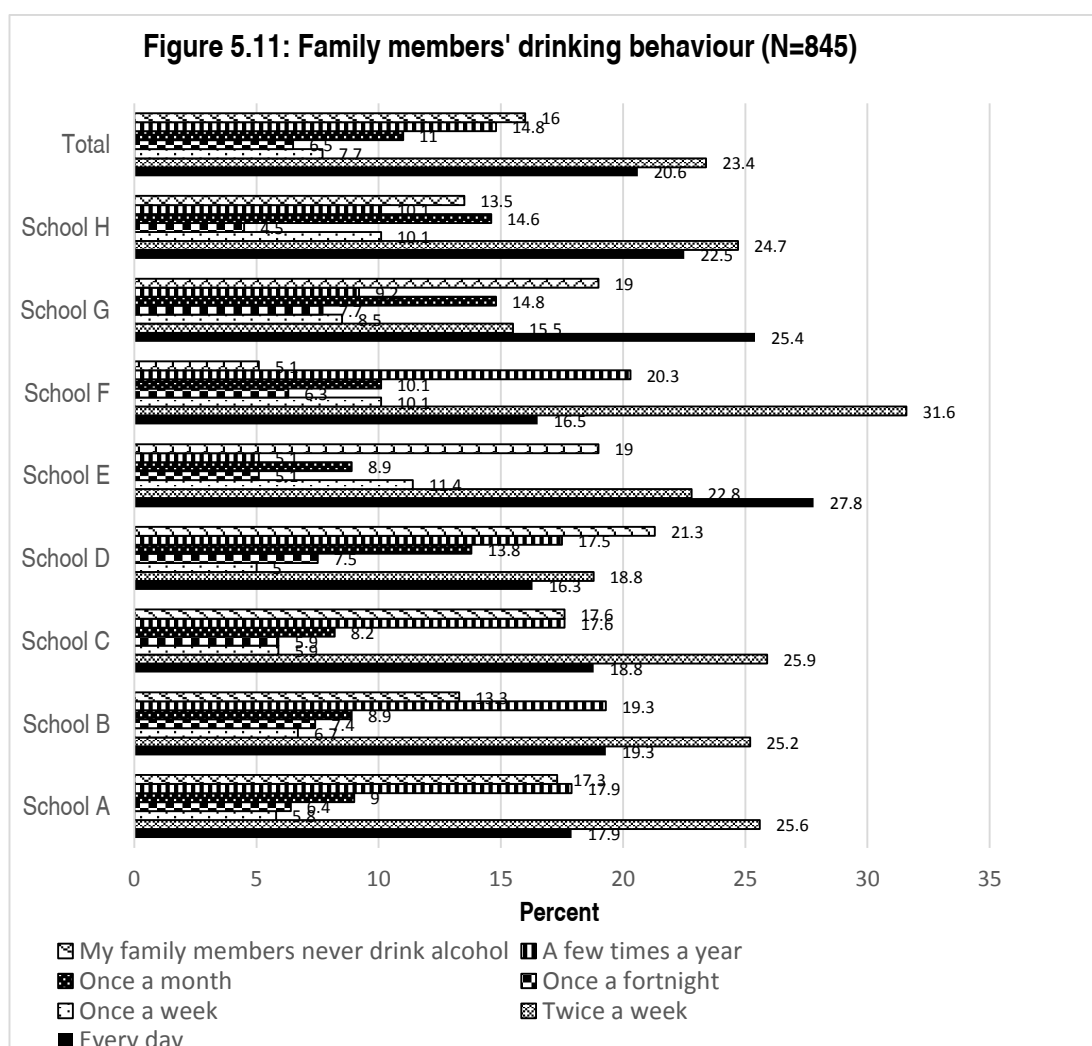
In case of father's drinking, most students in each school reported that fathers had drunk alcohol more than other family members except students in School H where most students indicated that their father had drunk alcohol less proportion than cousins/relatives (55.1% compared with 41.6%). The highest proportion of siblings' drinking was reported by students in School D (23.8%) followed by students in School H (13.5%). The highest proportion of mothers' drinking was reported by students in

School C (17.6%), School A (17.3%), and School B (17%). The greatest proportion (11.2%) of students who reported that their grandfathers or grandmothers had drunk alcohol was in School H.

The findings show that the family member most likely to have drunk alcohol was the father. This was reported by most students in almost every school. However, students in School H and School F mentioned that their cousins/relatives had drunk alcohol most.

### 5.3.10 Family members' drinking behaviour

Students were asked 'how often your family members consume alcohol?'. The following figure shows the findings from the survey.



About one fifth of students reported that their family members had frequently drunk twice a week (23.4%) and some students reported that family members drank every day (20.6%). A few participants said that their family members drank once a fortnight (6.5%).

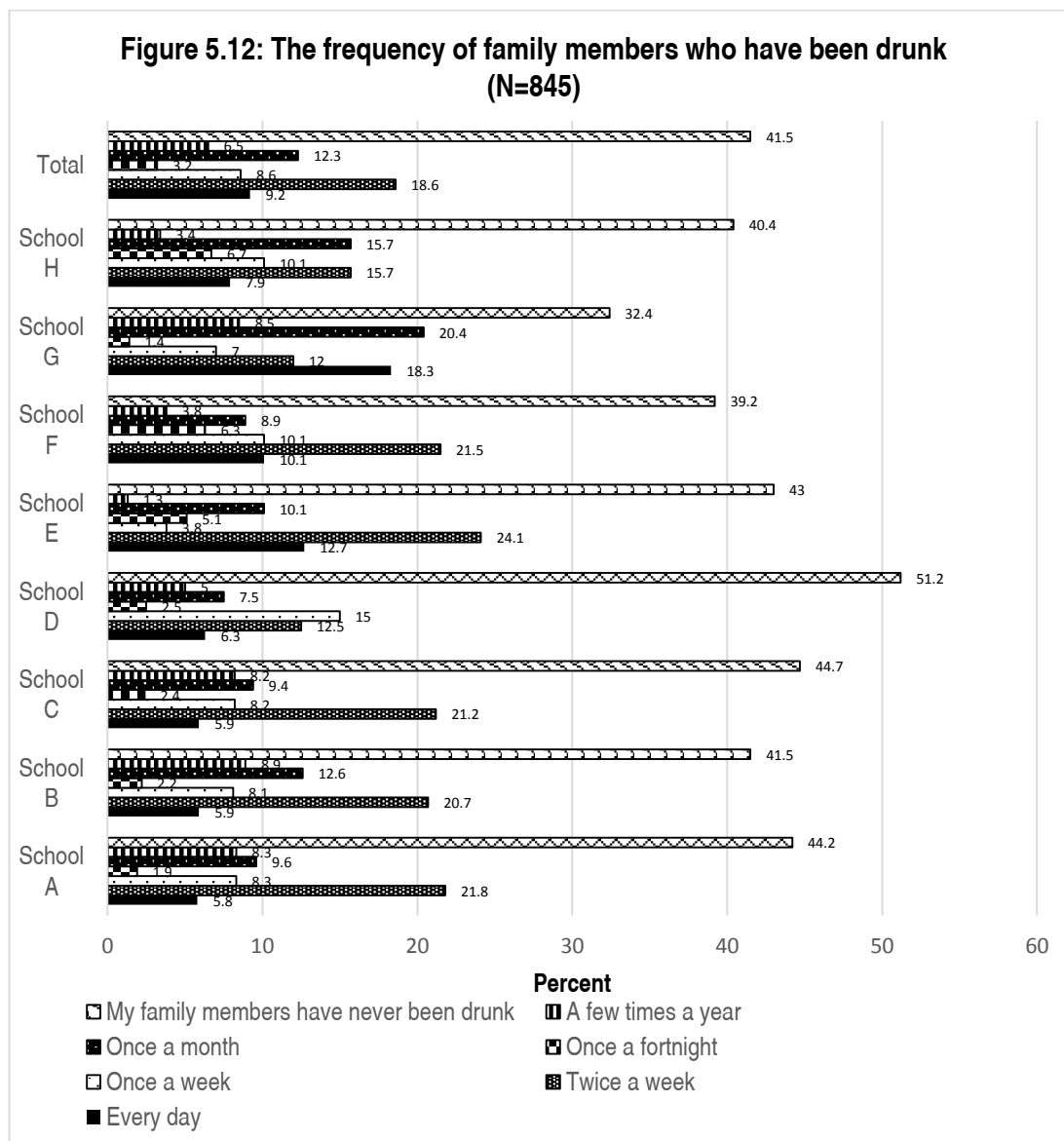


Figure 5.12 shows how often family members were reportedly drunk<sup>12</sup>. Most students said that their family members had been drunk twice a week (18.6%) followed by 12.3% who had been drunk once a month. A small proportion of students were reported

<sup>12</sup> 'Family members who have been drunk' means family members who get drunk after they drink alcohol. They will be more aggressive, without thinking about the impact on the future. Some people have not carefully thought; getting louder, possibly even having emotional changes, and slurred speech.

their family members got drunk every day (9.2%) following by 8.6% about once a week, 6.5% about a few times a year, and 3.2% about once a fortnight.

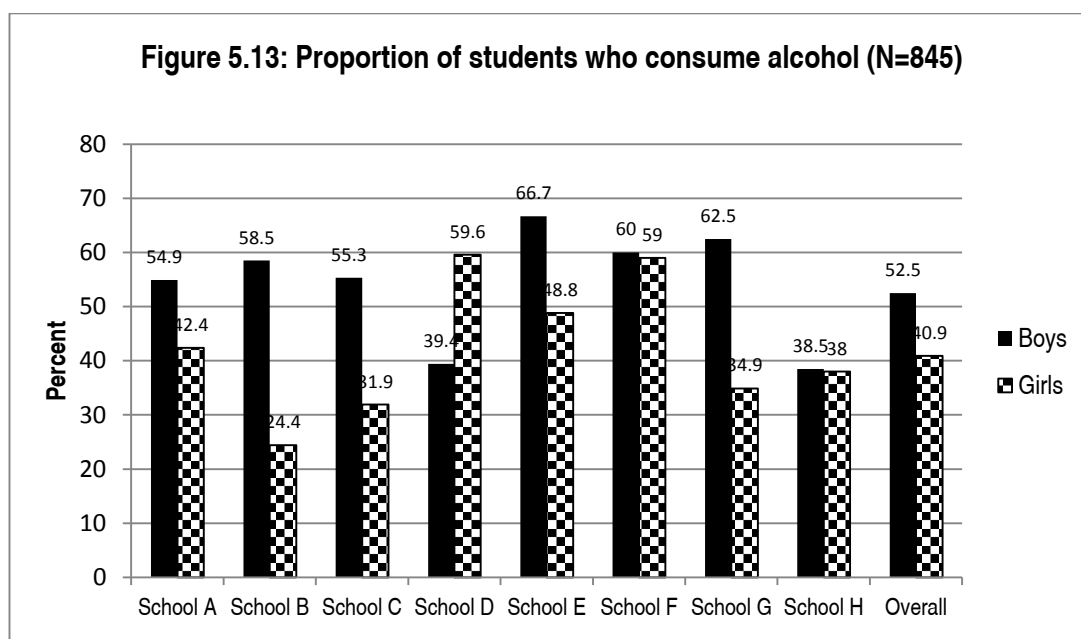
Since Chaveepojnkamjorn and Pichainarong (2007) and Plant and Plant (2001) claimed that family members' drinking related to young people's drinking, this encouraged me to investigate the findings from my survey. The data from Section 5.11.2 have been analysed to examine the association between the family members' drinking behaviour and young people's drinking behaviour. The results are presented in Part Two.

## 5.4 Questions about how often you drink

### The prevalence and characteristics of alcohol consumption by students in Petchaburi Province

#### 5.4.1 Self-reported alcohol consumption

Students were asked whether they had 'ever had a proper alcoholic drink, a whole drink, not just a sip' during the previous 30 days. The responses are shown in Figure 5.13.

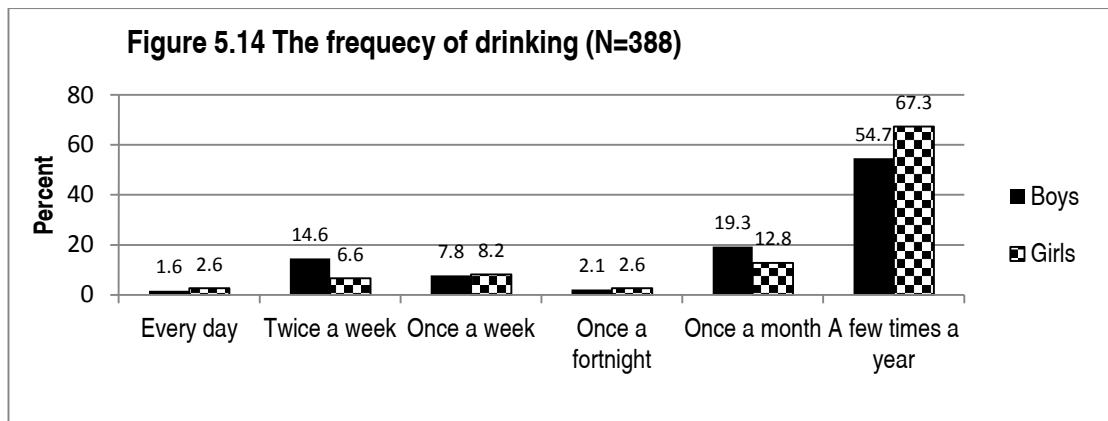


From Figure 5.13, 45.9% (n=845) of students reported that they had an alcoholic drink in the previous 30 days. Comparing students' drinking across the sample, boys were more likely to drink than girls (52.5% of boys compared with 40.9% of girls). It was a similar situation in each school where participants reported that boys were more likely to drink than girls. There was a contrast in two schools: School F and School H in that the proportion of boys and girls were equally likely to take an alcoholic drink. The students in these two schools live in the communities near the Thailand – Myanmar border, and are far away from the Petchaburi city centre, in rather a desolate area which is surrounded by forest. Some of the students in these two communities are from a hill tribe and respect the community culture which is made by the people in the community, for example children have to join the annual celebration for ghost ancestor ceremony, and this activity encourages young people to access alcohol.

There was an interesting finding in School D in that the proportion of girls who had drunk an alcoholic drink was higher than the boys' proportion. This school is located in an agricultural area and near the main road which many people come to as it is the main market for agricultural produce. This area is surrounded by community shops which sell alcohol and cigarettes, and it is close to nightclubs and bars. Moreover, on the day when I was collecting data most boys went to an ROTC programme, therefore more girls responded to my data collection.

#### **5.4.2 Usual frequency of drinking**

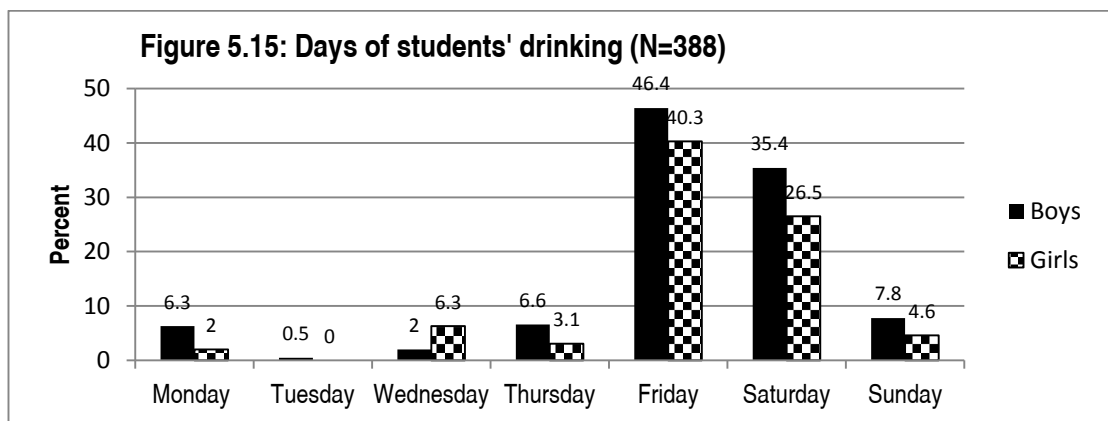
Students who had reported that they had an alcoholic drink during the previous 30 days were asked 'how often do you usually have an alcoholic drink?'. The following data shows the usual frequency of drinking of students who had ever consumed alcoholic drink.



The greatest proportion of students said that they drank an alcoholic drink a few times a year: 54.7% of boys compared with 67.3% of girls. A very small proportion of students said that they drank alcohol almost every day: 1.2% of boys compared with 2.6% of girls. The proportions of boys and girls who drank once a week and once a fortnight were similar. There was an increase in the proportion of boys who drank an alcoholic drink a few times a year when comparing with the other patterns, and it was a similar situation for the proportion of girls.

#### 5.4.3 Days on which students drank alcohol

Students who had consumed an alcoholic drink during the previous 30 days<sup>13</sup> before the day of the data collection were asked on which days they had drunk an alcoholic drink.



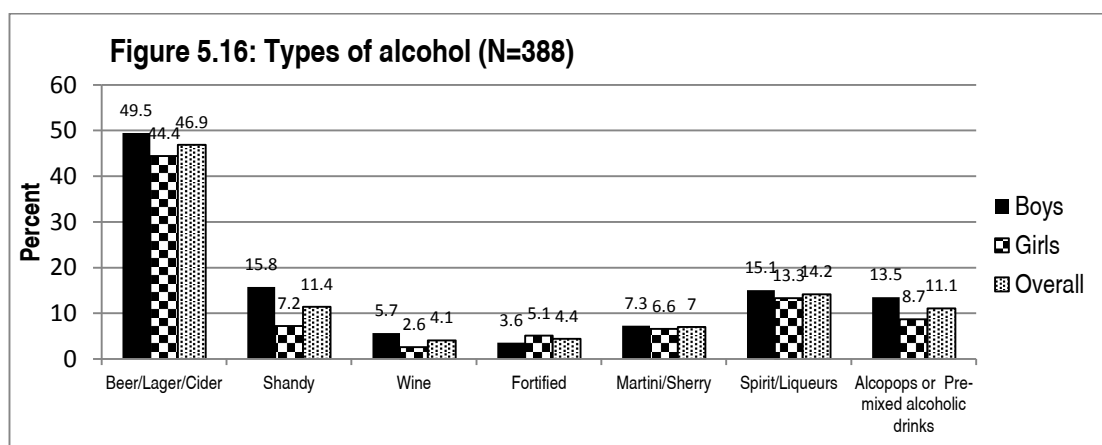
<sup>13</sup> Drinking during the previous 30 days defines as 'current drinking' (Assanangkornchai, Mukthong and Intanont, 2009) up to the point of completing the questionnaire.

Students were more likely to drink at the weekend than midweek. Friday and Saturday were the most popular days of the week for young people's drinking. In this case, Friday night was reported more than Saturday by both boys and girls. Of those who drank an alcoholic drink during the previous 30 days, 46.4% of boys and 40.3% of girls drank on Friday, and 35.4% of boys and 26.5% of girls had drunk on Saturday. In contrast, Tuesday was not popular for students for drinking an alcoholic drink. It was interesting that in terms of midweek drinking, girls usually drank more than boys on Wednesday, and this means girls usually went for a night out for drinking and were offered alcohol by males and gained entry free of charge to the pubs or bars.

## 5.5 Questions about what you drink

### 5.5.1 Types of alcohol which students consumed during the previous 30 days

This section presents the information on types of alcohol which students consumed during the previous 30 days. Students who completed the questionnaire reported their answers in the following data.



Students who had drunk an alcoholic drink were asked to report types of alcoholic beverages during the previous 30 days. To make clear about the types of alcohol, I provided information about each type of alcoholic drink by using a Power Point presentation and gave students a chance to ask questions before they completed the questionnaire.

Most students said that the most popular alcoholic beverages consumed during the previous 30 days for both genders was beer/lager/cider (49.5% of boys compared with 44.4% of girls), followed by spirits/liqueurs (15.1% of boys compared with 13.3% of girls), and alcopops (13.5% of boys compared with 8.7% of girls). Fewer students had drunk shandy, wine, fortified wine, and martini/sherry.

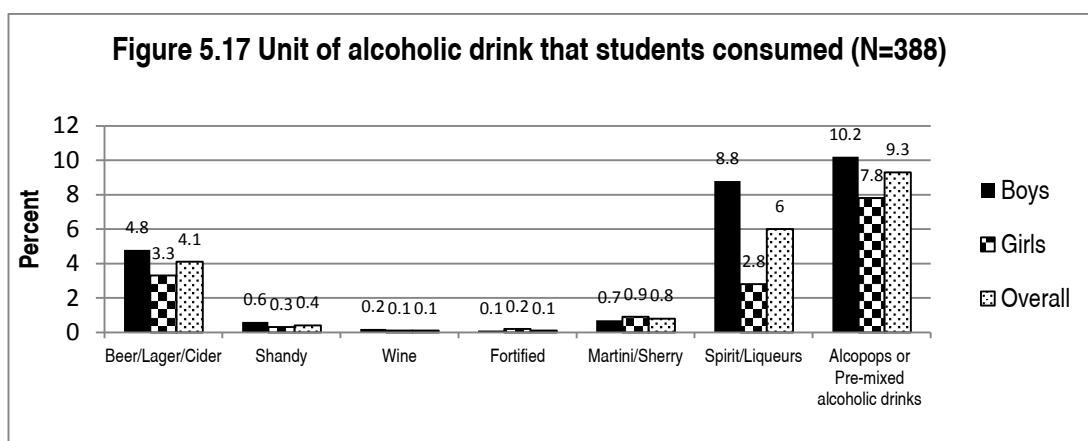
### 5.5.2 The unit of alcoholic drink which students consumed during the previous 30 days

Students were asked the number of pints, half pints, large cans, small cans, bottles, and glasses they had consumed. This was shown as pictures on the questionnaire (See more detail in appendix A). The number of those was converted into units to provide a standard measure of drinking alcohol by the SALSUS (Black *et al.*, 2008). Table 5.1 shows the conversion of each type of alcoholic drink into units.

<b>Table 5.1 Conversion factors for each type of alcoholic drinks into units of alcohol</b>		
<b>Type of alcohol drink</b>	<b>Measure</b>	<b>Units of alcohol</b>
Beer/lager/cider	Pint	2
	Half pint	1
	Large can	2
	Small can or bottle	1.5
	Less than half a pint	0.5
Shandy	Pint	1
	Large can	.75
	Half pint, small can or bottle	0.5
	Less than half a pint	0.25
Wine	Glasses	2
	Less than a glass	1
Fortified wine or spirits	Glasses	1
	Less than a glass	0.5
Alcopops	Can or bottle	1.5
	Less than a bottle	0.75



The following information shows the units of alcohol consumed.



In this section, students filled in the number of units of types of alcohol which they consumed during the previous 30 days by putting the number into the blank provided. The mean number of units of alcohol consumption was calculated for the students who reported drinking during the previous 30 days. Beer/lager/cider accounted for under half of students' (in Section 5.5.1) monthly intake with 4.1 units. Boys who drank consumed more beer/lager/cider than girls (4.8 units compared to 3.3 units). The same picture emerged with shandy consumption, and there were a few units in mean alcohol consumption of wine, fortified wine and martini. These types of alcohol were not popular for students as indicated in the previous section.

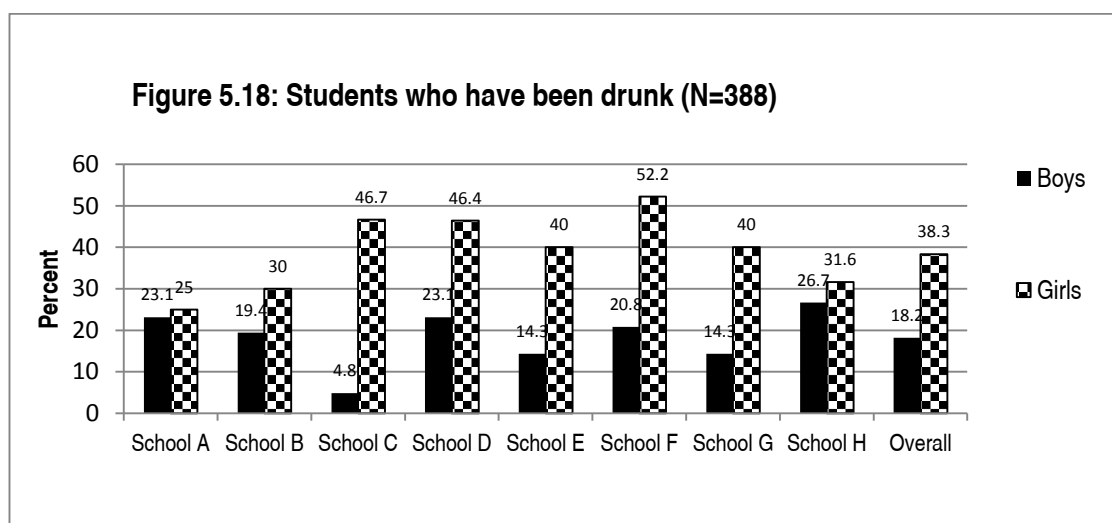
However, a very different picture was shown in the spirit/liqueurs and alcopops drinking group. Boys consumed 8.8 units of spirit/liqueurs compared with 2.8 units for girls, and boys reported higher units of alcopops consumption than girls (10.2 units of boys compared with 7.8 of girls). In relation to the results in Section 7.3.4.2 and 7.3.4.3, Chapter Seven, students said that spirit and 'Lao Pan'<sup>14</sup> were popular for them. Because of the taste and fashion of these drinks, they often drank these types of alcohol in high volume.

<sup>14</sup> Lao Pan alcohol mixed with fruit juice and spun in a blender. There are various colours depending on the colour of juice which is mixed into the alcohol.

## 5.6 Questions about the effects of drinking

### 5.6.1 Students who have been drunk

All students (n=388) who had ever consumed alcohol during the previous 30 days were asked whether they had been drunk. ‘Students who have got drunk’ means students who get drunk after they drink alcohol<sup>15</sup>. The following figure shows the information concerning the students’ answers.



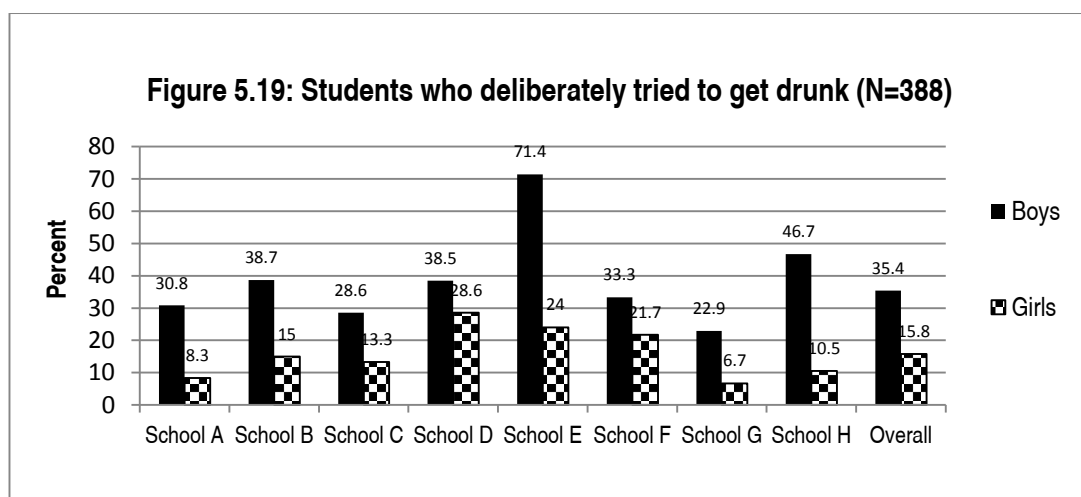
Overall, girls who had consumed an alcoholic drink were more likely to report having been drunk than boys (38.3% of girls, compared with 18.2% of boys). Among boys who had ever had an alcoholic drink, boys in School H were more likely to report having been drunk (26.7%), than in the other schools. Among girls who had consumed an alcoholic drink, the greatest proportion was reported by girls in School F (52.2%), followed by School C and D.

This section shows a whole picture of students who have got drunk after taking an alcoholic drink. The next section will present the proportion of students who try to get drunk and have been ‘really drunk’.

<sup>15</sup> Students who have got drunk means students who get drunk after they drink alcohol. They will be more aggressive, without thinking about the impact on the future. Some people have not carefully thought; getting louder, possibly even having emotional changes, and slurred speech.

### 5.6.2 Students who deliberately tried to get drunk

Following the finding in Section 5.4.1, all students who had had an alcoholic drink during the previous 30 days were asked whether they had deliberately tried to get drunk. The following figure shows data from students' answers.

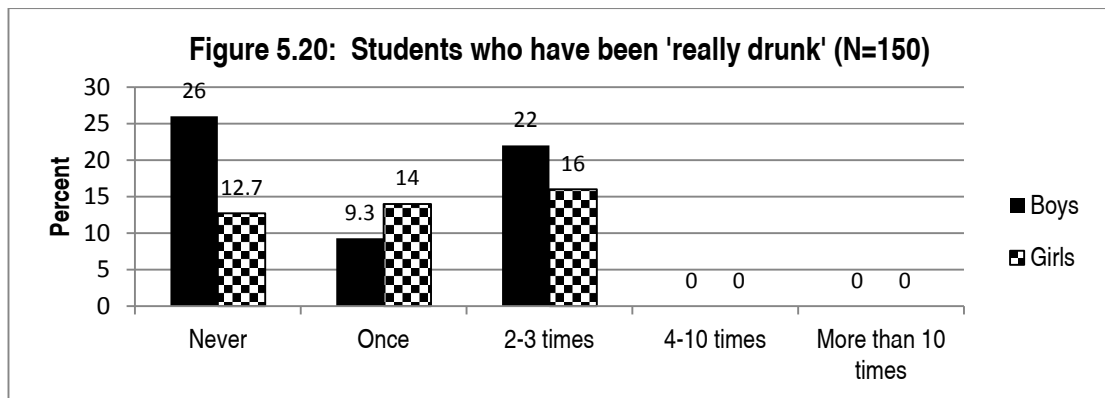


Boys who had consumed an alcoholic drink during the previous 30 days had deliberately tried to get drunk more than girls (35.4% of boys, compared with 15.8% of girls). Boys in every school reported that they deliberately tried to get drunk with the average under 40%. In contrast, there was a higher proportion in School H and E (46.7% and 71.4% respectively). Girls in every school were less likely than boys to deliberately try to get drunk. The greatest proportion of girls who tried to get drunk was in School D (28.6%).

### 5.6.3 Students who have got 'really drunk'

The previous section shows the finding that students tried to get drunk during the previous 30 days. In this section, I present the information about students who had ever tried to get drunk or whether they had ever been 'really drunk'<sup>16</sup>.

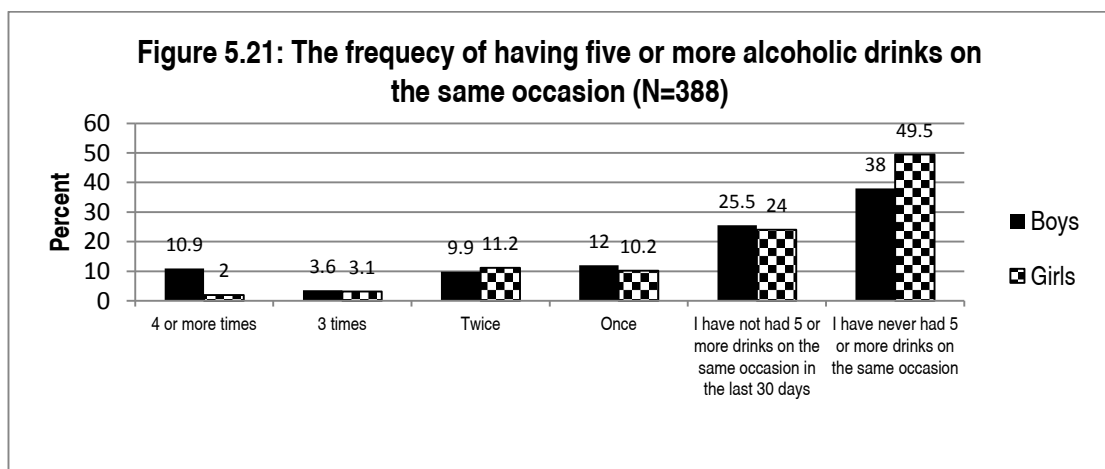
<sup>16</sup> 'Really drunk' is defined as students who tried to get drunk (Section 5.7. 8) and then they got really drunk after drinking alcohol.



Boys were more likely to report that they had never ever been really drunk than girls (26% of boys, compared with 12.7% of girls). In the case of students who had been really drunk, most boys and girls said that they had been really drunk 'two - three times' during the previous 30 days. 9.3% of boys and 14% of girls reported having been really drunk at least once. Nevertheless, no students reported that they had been 'really drunk' four - ten times or more than 10 times.

#### 5.6.4 Frequency of having five or more alcoholic drinks on the same occasion

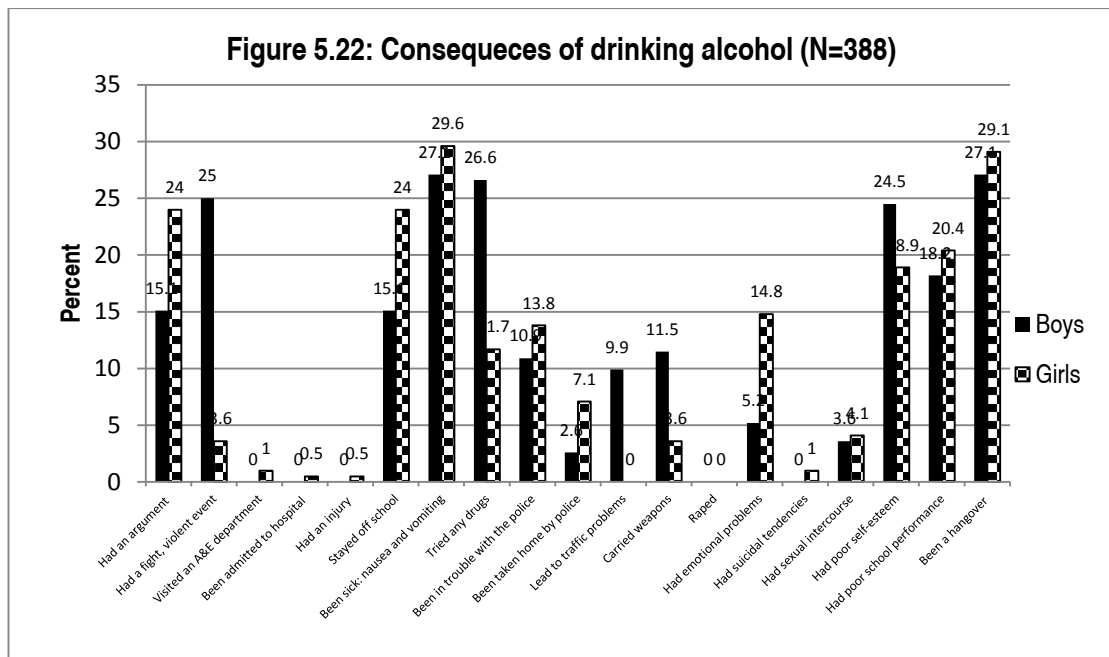
Students who had consumed an alcoholic drink during the previous 30 days were asked how many times they had had five or more drinks on the same occasion. In Section 4.4, 'five or more drinks on the same occasion' is defined as 'binge drinking' (Department of Health and Human service, 2011; National Advisory Council, 2004). This section presents information about students' binge drinking.



Girls were more likely to say that they never had five or more drinks on the same occasion than boys (49.5% of girls, compared with 38% of boys). In contrast, the proportion of boys who said they had not had five or more drinks on the same occasion during the previous 30 days was greater than girls (25.5% of boys, compared with 24% of girls). A lesser proportion of students who answered this question were stated for categories of 'once', 'twice', 'four or more times', and 'three times'. The finding shows that the proportion of students who were defined as not binge drinkers was greater than the proportion of students who were binge drinkers.

### **5.6.5 Consequences of drinking alcohol**

Students who had consumed an alcoholic drink were asked about the consequences of drinking alcohol. As shown in Section 4.4, I have modified this question from SALSUS (Black *et al.*, 2008) with the consequences of drinking alcohol included: had an argument; had a fight; visited an A&E department; been admitted to hospital overnight; had an injury that needed to be seen by a doctor; been taken home by the police; stayed off school; been sick; suffered nausea and vomiting; tried any drugs; and been in trouble with the police. From the literature review, I found that many researchers have stated more consequences of drinking alcohol than in the SALSUS data (Assanangkornchai, Mukthong, and Intanont, 2009; Peleg-Oren *et al.*, 2009; Assanangkornchai *et al.*, 2010) which I present a detail in Section 4.4, Chapter Four. Thus I modified this question by adding more consequences including: lead to traffic problems; carried weapons; was raped; had emotional problems; had suicidal tendencies; had sexual intercourse; had poor self-esteem; had poor school performance or had a hangover. Figure 5.22 shows data how students responded to this question.



It was common for students to report more than one effect for this question. Most students said that the three common effects for boys and girls from drinking alcohol were ‘being sick: nausea and vomiting’; ‘had a hangover’; and ‘had an argument’. Moreover, boys were more likely to report that they had tried any drug; had poor self-esteem; had a fight; and carried a weapon than girls. In contrast, girls said that they had stayed off school; had poor school performance; had emotional problems; and had been in trouble and taken home by police more often than boys.

In my study, no boys said that they had visited an A&E department; been admitted to hospital; had an injury and needed to see a doctor; and had suicide tendencies, whereas a very small proportion of girls had these negative outcomes. Similarly, there were no girls who said that drinking alcohol had led to traffic problems; and carried a weapon after drinking, whereas around one in ten of boys said this.

The negative consequence that neither boys and girls got from drinking alcohol was to be ‘raped’, and there was an equal proportion of boys and girls who had sexual intercourse without ever using a condom (3.6% of boys, compared with 4.1% of girls).

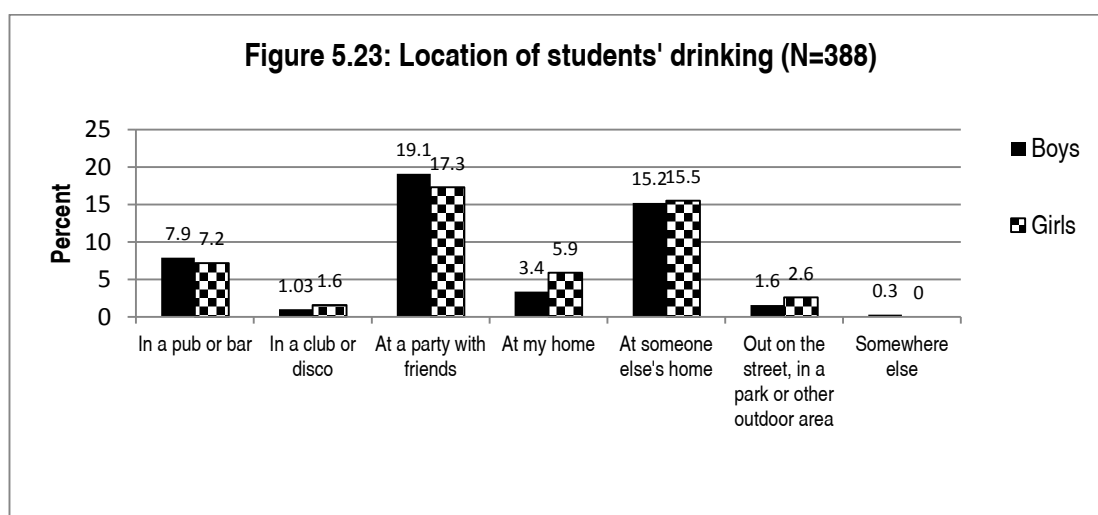
Relating to the findings from the focus group and in-depth interviews in Section 7.5, participants commented that the common negative consequences from drinking

alcohol by young people included: accidents, changes in individual behaviour, fighting, poor school performance, health problems: getting drunk, vomiting, having a fever and a cough. This means the findings from the survey can be explored in, and confirmed by, the qualitative study.

## 5.7 Questions about where you drink and with whom

### 5.7.1 Location of students' drinking

Students who had ever drunk an alcoholic drink were asked the location of their drinking. The following figure presents this information.



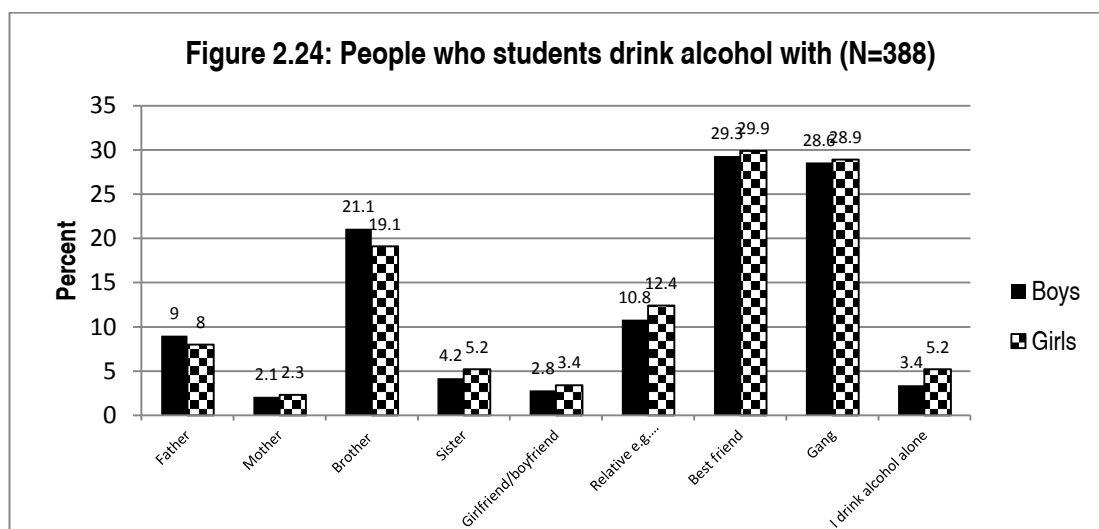
Both boys and girls were most likely to drink at parties with their friends. In this case, the proportion of boys was slightly greater than girls (19.1% of boys, compared with 17.3% of girls). There was an equal proportion of boys and girls who usually drank at someone else's home (15.2% of boys and 15.5% of girls), or in a pub or bar (7.9% of boys and 7.2% of girls). This supports the information in Section 7.3.5 where participants identified that young people were more likely to drink in a private place (their friend's house).

A small proportion of students said that they drank an alcoholic drink in their own home. In this case, girls were more likely than boys to consume alcohol in this place (5.9% of girls, compared with 3.4% of boys). Consuming alcohol in a club or disco

and drinking outside (on the street, in a park or other outdoor area) were not familiar ways for students. A very small proportion of boys said that they sometimes drank somewhere else (in school or at a funeral in the temple).

### 5.7.2 Who did students drink alcohol with?

Students were asked how often they drank with friends, family members or on their own. Figure 5.24 shows students' information.

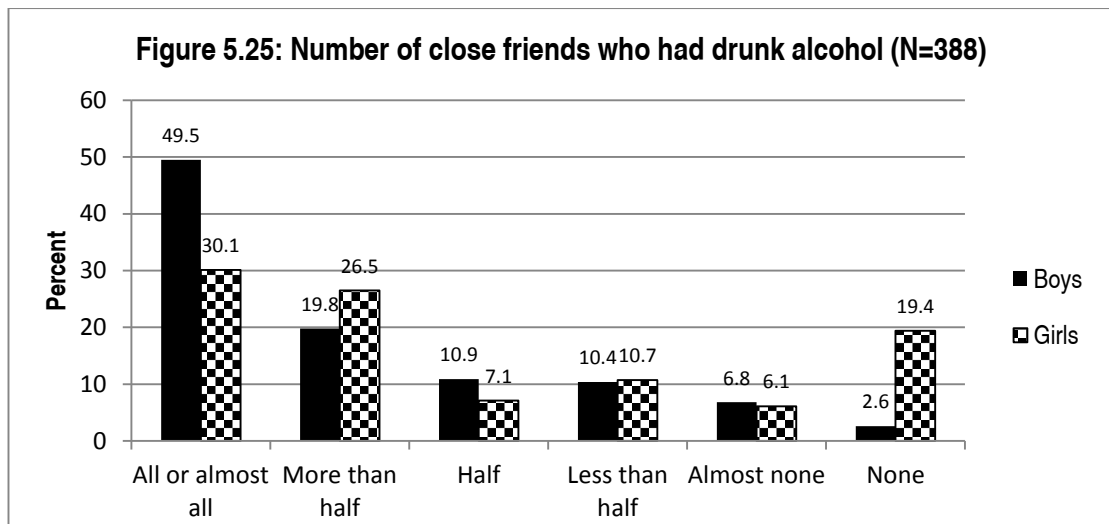


Students who consumed alcohol were most likely to say that they usually drank with their best friends (29.3% of boys and 29.9% of girls) and gang (28.6% of boys and 28.9% of girls). Their brothers and other relatives were also a popular choice of drinking companion. However, students were less likely to drink with their father and seldom with their mother. Drinking alone, with sister and girlfriend/boyfriend were reported by a few students. This pattern was broadly similar for both sex groups.

### 5.7.3 Number of close friends who had drunk alcohol

Students who had consumed an alcoholic drink were asked 'how many of your close friends drink alcohol?'



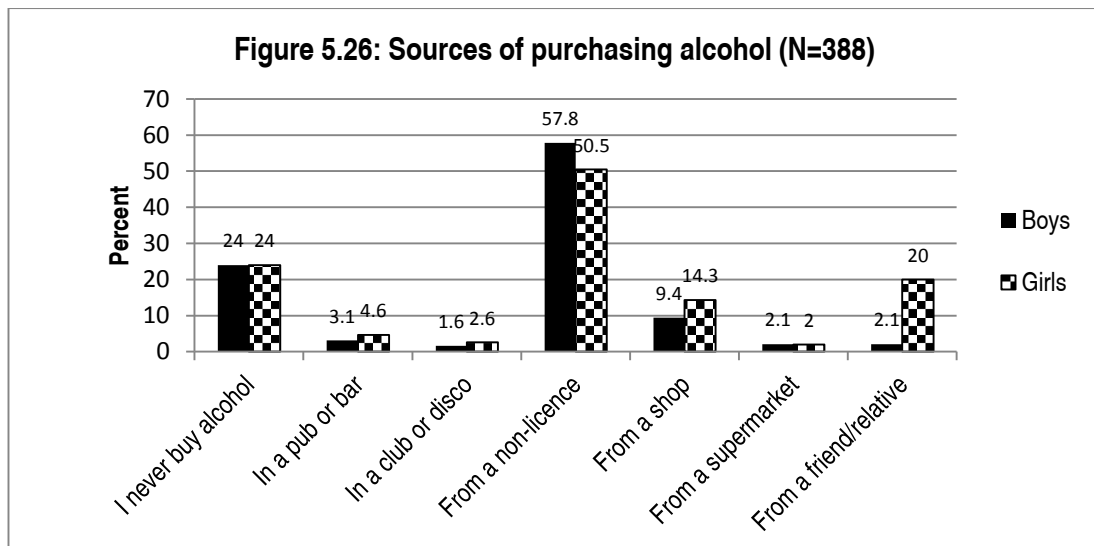


Students who reported drinking alcohol during the previous 30 days were more likely to report that ‘all or almost all’ of their friends also drank alcohol. Boys were more likely than girls to say ‘all or almost all’ of their friends drank an alcoholic drink (49.5% of boys compared with 30.1% of girls). This links to the data in Section 5.7.2 which showed that students in all age groups usually drank alcohol with their best friends and gang more than with other people. Girls who drank alcohol in the previous 30 days were more likely than boys to report that ‘more than half’ or ‘none’ of their friends drank alcohol. However, there was an equal proportion of both sex groups who said that ‘less than half’ and ‘almost none’ of their friends drank an alcoholic beverage.

## 5.8 Questions about buying alcohol

### 5.8.1 Sources of buying alcohol

This data show where students usually buy alcohol, attempts to purchase it from various sources, or whether they have got from friends or relatives. However, this is not to say that all alcohol consumed by students is purchased, as it may be given to them by friends or relatives.



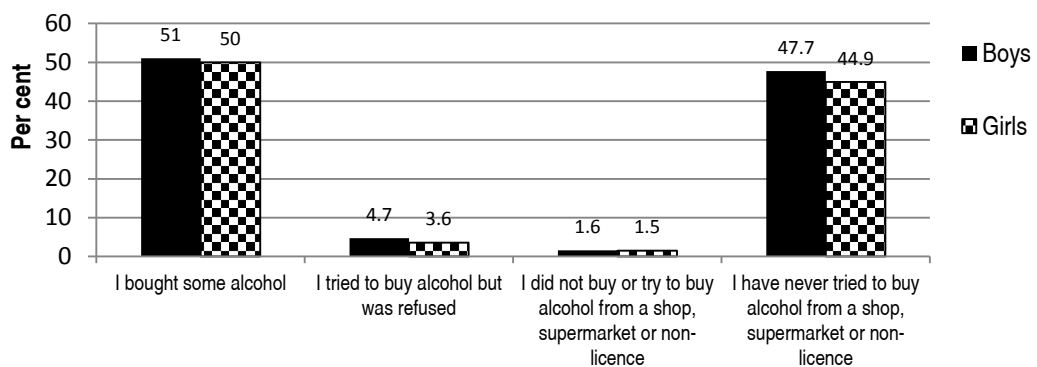
Students who drank alcohol were asked if they bought alcohol, and where they usually bought it. The commonest place for buying alcohol for students was non-licence shops in the community. Boys who drank were more likely than girls to say that they got alcohol from this place (57.8% of boys, compared with 50.5% of girls). Girls were more likely to report that they usually got alcohol from friends or relatives who bought alcohol for them (20%) which showed a difference in boys who were not likely to get alcohol this way (2.1%).

Purchasing alcohol from shops (minimarts) was not popular for students (9.4% of boys compared with 14.3% of girls). The information in Section 5.7.1 showed that drinking in a pub, bar, club or disco was not familiar for students, thus the use of methods to buy alcohol in these areas were relatively rare such as buying from pub or bar (3.1% of boys and 4.6% of girls); club or disco (1.6% of boys and 2.6% of girls), or a supermarket (2.1% of boys and 2% of girls). However, just under a quarter (24%) of both sex groups reported that they never bought alcohol.

### **5.8.2 Students who attempted to buy alcohol from a shop, supermarket or non-licence shop**

Students who had consumed an alcoholic drink were asked whether they had tried to buy alcohol from a shop, supermarket or non-licence shop in the last month. The following figure shows the information obtained from this question.

**Figure 5.27: Students who attempted to buy alcohol from a shop, supermarket or non-licence shop (N=388)**

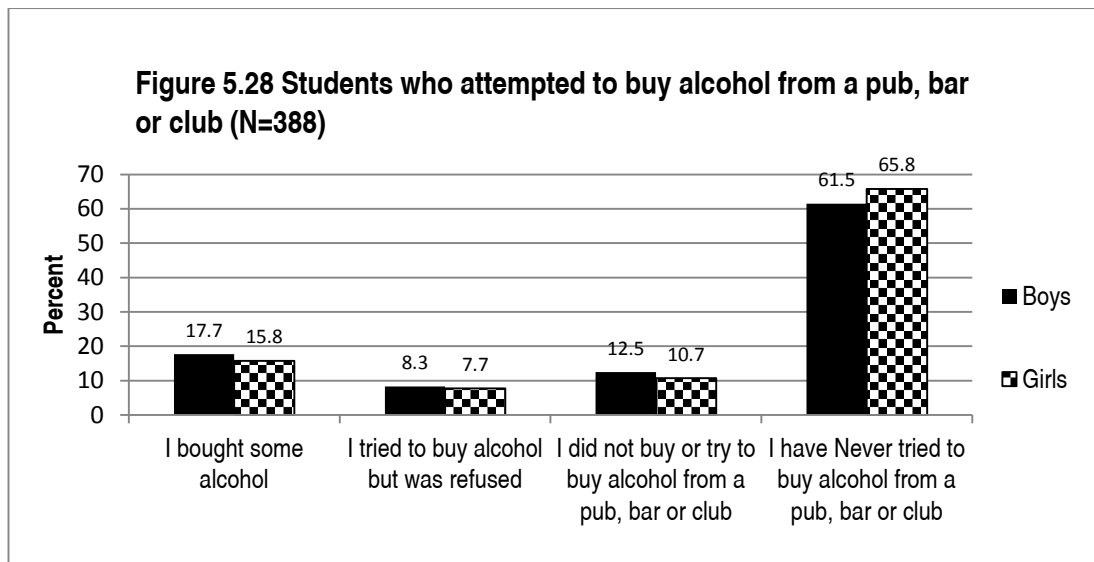


During the previous 30 days before the survey, around half of the students who had drunk an alcoholic drink said that they attempted to buy alcohol from a shop/supermarket/non-licence shop. There was a similar proportion of boys and girls who reported that they attempted to buy alcohol (55.7% of boys compared with 53.6% of girls). Students were more likely to be successful in buying alcohol than to have tried but failed: 50.5% were successful (51% of boys compared with 50% of girls) and 4.1% were refused (4.7% of boys compared with 3.6% of girls). In this case, both genders were successful in buying alcohol in similar proportions.

According to data in Section 5.8.1 showing the sources of alcohol, most students usually bought alcohol from non-licensed shops in their communities. This related to the behaviour of students who tried to purchase alcohol and succeeded in buying because the non-licensed shops did not check their ID or seek proof of the age of the buyers as indicated by the information obtained from participants and shown in Section 7.4.4.2.

### 5.8.3 Students who attempted to buy alcohol from a pub, bar or club

Students who had consumed an alcoholic drink during the previous 30 days were asked whether they had tried to buy alcohol from a pub, bar or club in the last month. The following figure shows their information.

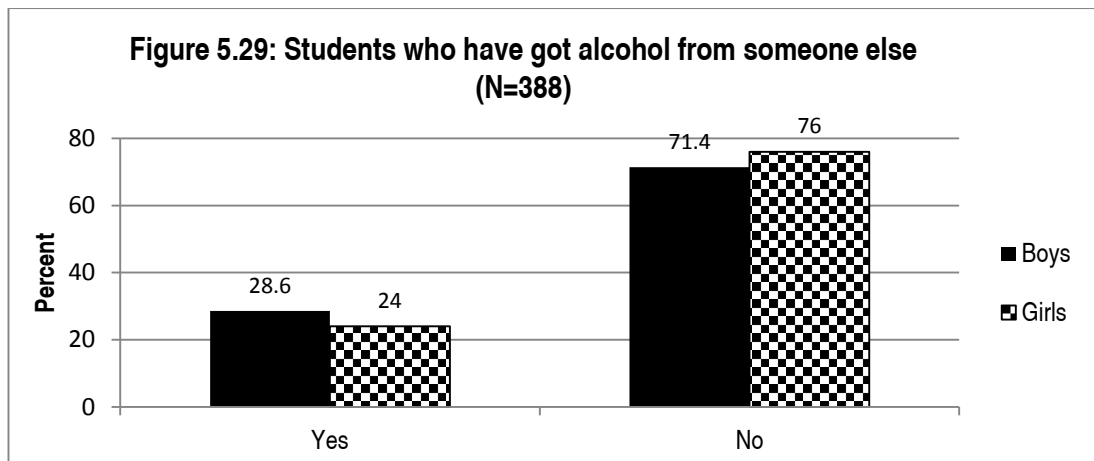


In Section 5.8.3 buying alcohol in pub, bar, or club was not popular for students. Most students said that they never tried to buy alcohol from a pub, bar or club. Girls were more likely to say this than boys (65% of girls compared with 61.5% of boys).

However, a few students reported that they tried to buy alcohol in these places during the last month (26% of boys and 23.5% of girls). Boys were more likely to be successful in buying alcohol than girls (17.7% of boys compared with 15.8% of girls). Moreover, if I compared buying alcohol from a shop, supermarket or non-licence shop, I found that the proportion of success in buying in a pub, bar or club was less than the proportion of success in buying from a shop, supermarket or non-licence shop.

#### 5.8.4 Students who obtained alcohol from someone else

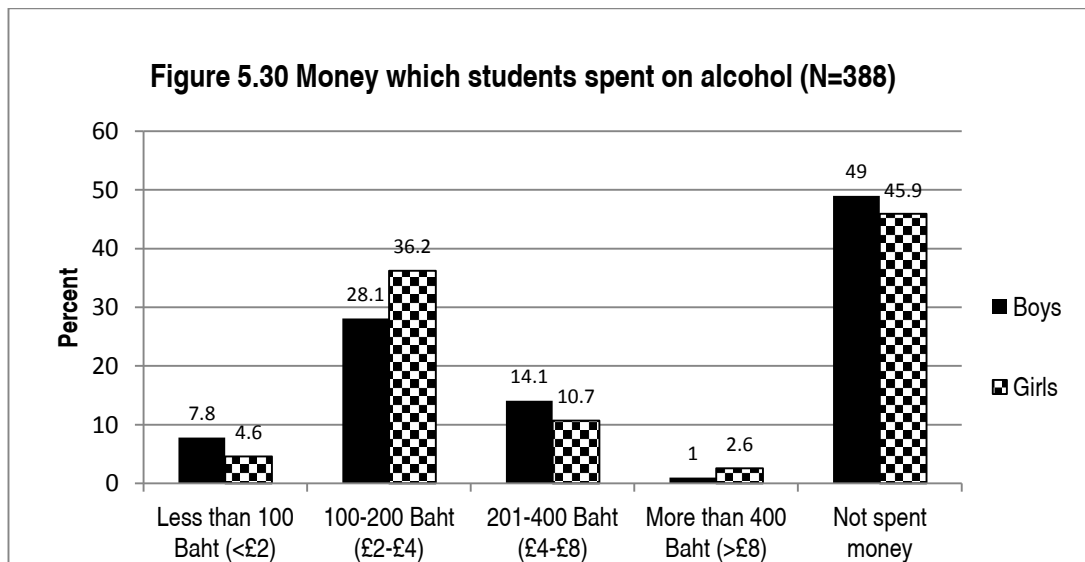
There was a similar response compared with the previous section. Students who had had an alcoholic drink were asked ‘have you got anyone else to buy any alcohol for you in the last month?’. The following information shows the result from their response.



Most students said there was no one else to buy alcohol for them. Both girls and boys were more likely to say this (76% of girls compared with 71.4% of boys). Moreover, both genders were more likely to say that they had got someone else to buy alcohol for them in the past month (28.6% of boys and 24% of girls).

### 5.8.5 Money which students spent on alcohol

Students who had consumed alcohol were asked the amount of money that they usually spent on any one occasion of drinking alcohol. The following figure presents the information from students who completed the questionnaire.



Most boys and girls said that they did not spend money on their occasional drinking: 49% of boys and 45.9% of girls. Students who spent money on their drinking were

more likely to say that they usually spent 100-200 Baht (£2-£4) on any one occasion. In this range, girls were more likely to spend money on alcohol than boys: 36.2% of girls reported that they spent some money on alcohol, compared with 28.1% of boys. On the other hand, few students said that they spent 'more than 400 Baht (>£4)': 1% of boys compared with 2.6% of girls.

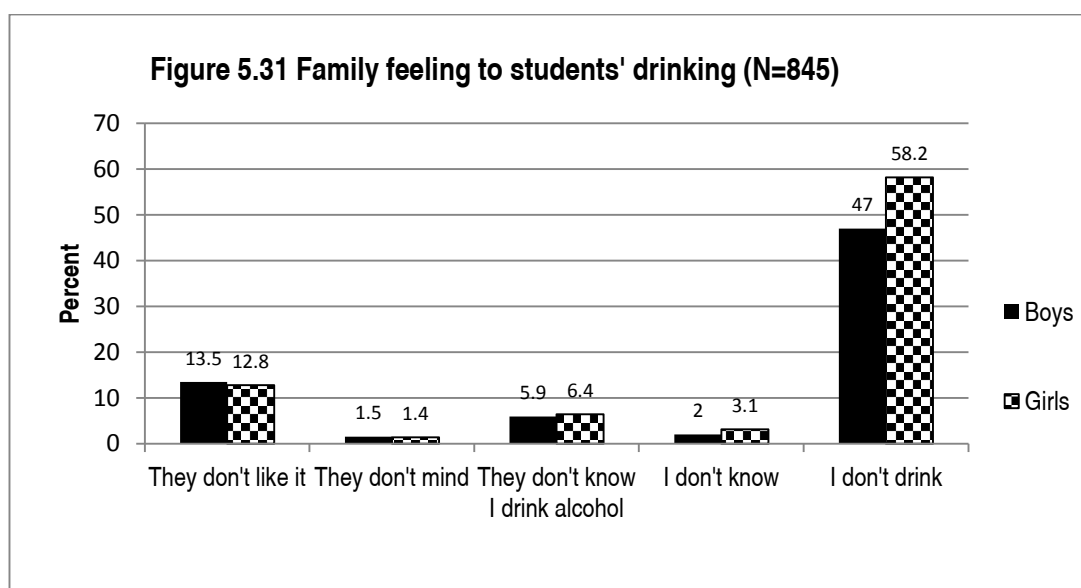
Among both sex groups, boys were less likely to spend money on alcohol than girls. In total, 51% of boys spent some money on their drinking while 54.1% of girls did. However, the patterns of spending money for boys and girls were similar.

Referring to data in Section 5.3.4 which showed students' monthly expenditure, most students said that their monthly expenditure was less than 1,000 Baht (<£20). This showed that students had not much money to spend on their drinking on any one occasion.

## 5.9 Questions about drinking and your family attitude

### 5.9.1 Family feeling to students' drinking

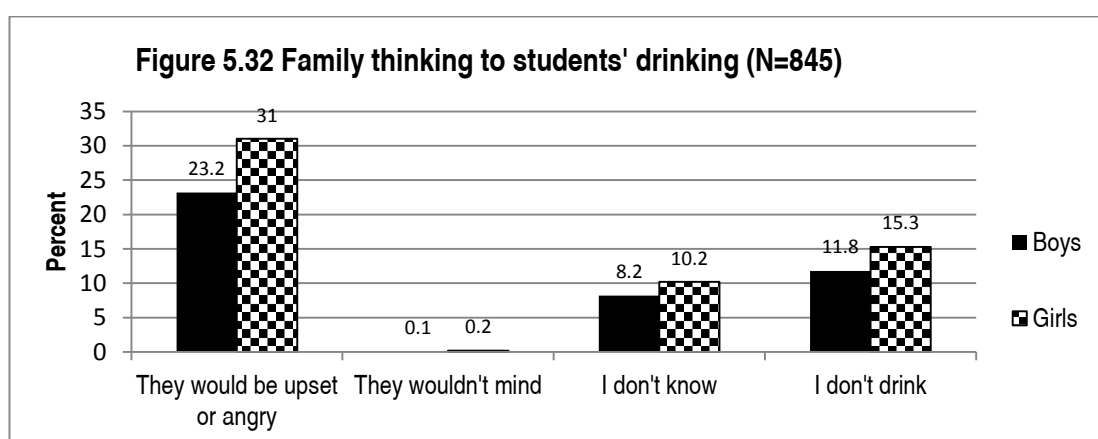
Students who had consumed an alcoholic drink were asked what their family's feeling was about their drinking behaviour. Students provided their information and I present it in the following figure.



Both genders who had consumed alcohol said that their family ‘did not like’ them drinking. Boys and girls were more likely to say this (13.5% of boys compared with 12.8% of girls). Lesser proportions of boys and girls reported that their family ‘did not mind’ them drinking; a further 5.9% of boys and 6.4% of girls mentioned that their families ‘did not know’ that they drank.

### 5.9.2 Family thinking towards students’ drinking

In this section I present the family’s thinking on their children’s drinking. Students who had consumed alcohol answered the question which asked ‘how do you think your family would feel if you started drinking alcohol?’.

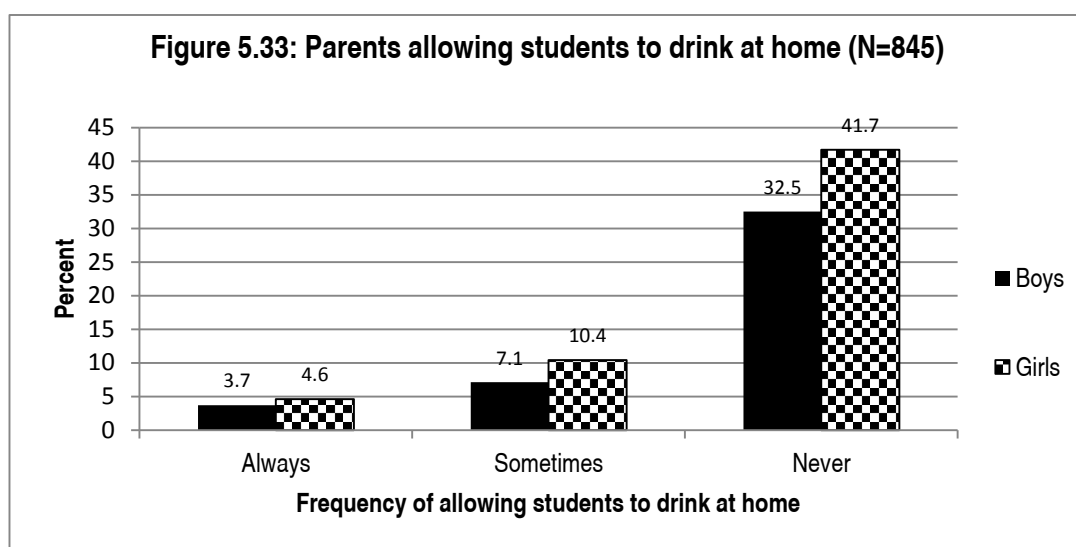


The situation was very similar to the previous section. Most students said that their family would be upset or angry with them if they were to start drinking. Girls were slightly more likely to report this than boys: 31% of girls compared with 23.2% of boys. A fewer proportion of students, a similar proportion of both genders, reported that their family ‘wouldn’t mind’ if they were to start drinking. Less proportion of students (8.2% of boys and 10.2% of girls) said that they did not know what their family would think if they were to start drinking.

### 5.9.3 Parents allowing students to drink at home

This section presents the information about parents who allow their children to drink at home. Students who had consumed an alcoholic drink asked permission from their

parents or guardians to allow them to drink alcohol at home, and the results are shown in the following figure.



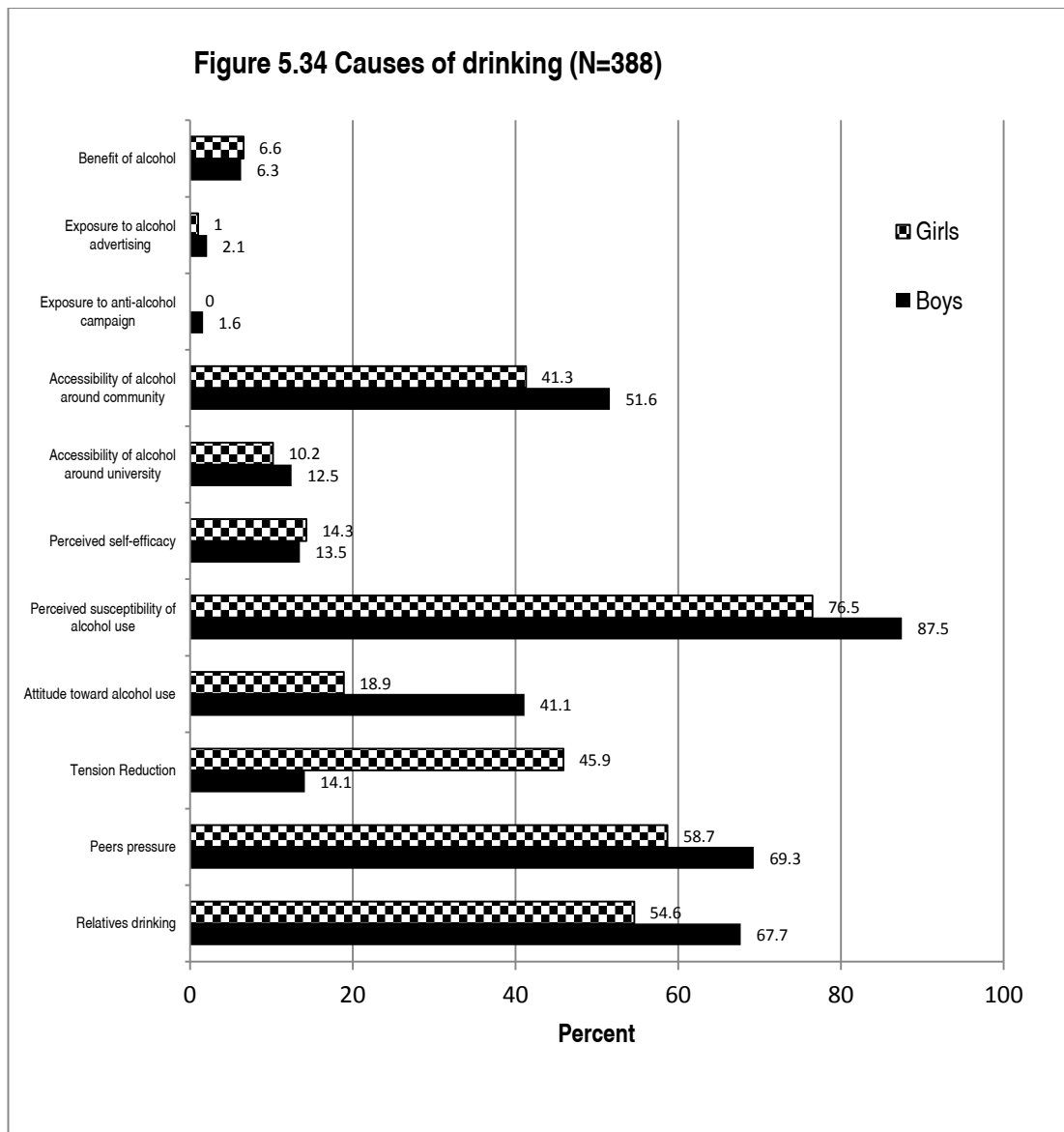
The two previous sections showed that students' families did not like it if their children drank alcohol, and would be upset if their children started drinking. As presented in this section, most students also said that their parents never allowed them to drink at home. Both genders of most students were more likely to report this situation: 32.5% of boys compared with 41.7% of girls. Among both sex groups, girls were slightly more likely to say that their parents allowed them to drink at home sometimes than boys (10.4% of girls compared with 7.1% of boys). There was a quite similar situation in that girls were more likely to say that they were always allowed to drink at home compared with boys (4.6% of girls compared with 3.7% of boys).

## 5.10 Questions about why you drink

### 5.10.1 Causes of drinking

In this section, students who reported ever having an alcoholic drink were asked for the causes of their drinking. The following figure shows the students' responses.



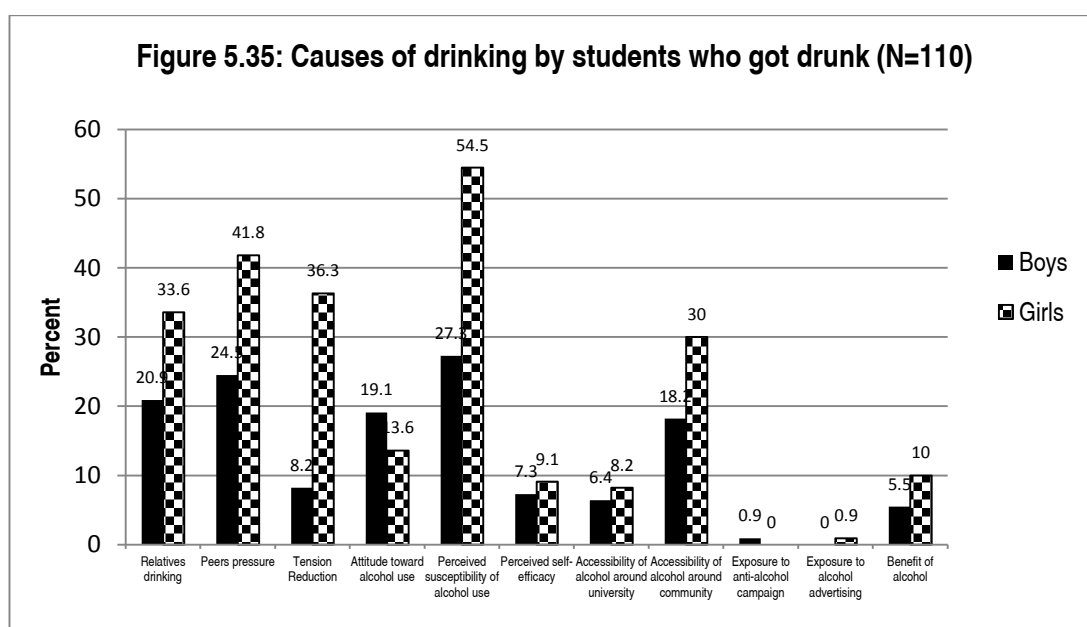


According to Figure 5.34, most students showed that the four most common causes of their drinking included being susceptible to alcohol use: students wanted to try drinking alcohol and they wanted to know how it felt after drinking; peers pressure; relatives' drinking; and accessibility of alcohol around the community, while the three least common causes of students' drinking were exposure to anti-alcohol campaigns, exposure to alcohol advertising, and perceived benefit: 'it's good for health'.

Among both genders who drank alcohol, most students drank alcohol because they were more susceptible to alcohol use: students wanted to try drinking alcohol and they wanted to know how it felt after drinking. Boys were more likely to report this cause

of drinking than girls (87.5% of boys compared with 76.5% of girls), followed by peer pressure, relatives' drinking, and accessibility of alcohol around community. These patterns were similar in both sex groups.

Boys who had drunk alcohol were more likely to report that 'attitude toward alcohol use': behaving like an adult, enjoyment, was the cause of their drinking compared with girls (41.1% of boys compared with 18.9% of girls). In contrast, girls were more likely to use alcohol for reducing their tension: for a broken heart, grief loss and loneliness than boys (45.9% of girls compared with 14.1% of boys). Some students, with a similar proportion of boys and girls, said that they drank alcohol because they wanted to encourage self-efficacy, and accessibility of alcohol around school or university.



Among students who got drunk from drinking alcohol, the common causes of students' drinking were similar to the finding in Figure 5.34 including: more susceptible to alcohol use; peer pressure; relatives' drinking; and accessibility of alcohol around community. However, there was a difference in the proportion of boys and girls. In Figure 5.35, girls were more likely to say that these four common causes affected their drinking compared with boys. Similarly exposure to anti-alcohol campaigns, exposure to alcohol advertising, and perceived benefit: 'it's good for health' were reported to slightly affect young people's drinking.

## **Part Two: The association analysis of variables**

### **5.11 The exploration of the association between different variables of students who had consumed alcohol**

In particular consideration of what factors are associated with the drinking behaviour of young people in Petchaburi Province, the following section presents information exploring the association between different variables. Data include demographic information, data relating to family members' drinking, data relating to students' drinking patterns, sources of buying alcohol, and data relating to family attitudes on students' drinking.

#### **5.11.1 The association between demographic information and students' alcohol consumption behaviour**

The literature identifies associations between a range of demographic variables and young people's drinking behaviour. I therefore explored associations between the demographic data and drinking behaviour in my data. The following table shows the association between demographic information (which is an independent variable) including sex, school year, age, family member relationship, living arrangement, students' monthly expenditure, and family income, and students' alcohol consumption behaviour (dependent variable).

Table 5.2 The association between demographic information and students' alcohol consumption behaviour				
Students' alcohol consumption behaviour	Students who had consumed alcohol  N= 388	Students who had never consumed alcohol  N= 457	Test / Significance	P value
Sex				
Male	192 (49.5%)	174 (38.1%)	Pearson Chi-Square /  Sig <sup>17</sup>	P = .001
Female	196 (50.5%)	283 (61.9%)		
School year				
Matthayomsuksa 4	105 (27.1%)	171 (37.4%)	Pearson Chi-Square /  Sig	P = .000
Matthayomsuksa 5	128 (33.0%)	165 (36.1%)		
Matthayomsuksa 6	155 (39.9%)	121 (26.5%)		
Age				
15 years	26 (6.7%)	40 (8.8%)	Pearson Chi-Square /  N/S <sup>18</sup>	P = .261
16 years	152 (39.2%)	190 (41.6%)		
17 years	111 (28.6%)	137 (30.0%)		
18 years	92 (23.7%)	81 (17.7%)		
19 years	7 (1.8%)	9 (2.0%)		
Grade Point Average (GPA)				
1.01-2.00	61 (15.7%)	54 (11.8%)	Pearson Chi-Square /  Sig	P = .045
2.01-3.00	197 (50.8%)	215 (47.0%)		
3.01-4.00	130 (33.5%)	188 (41.1%)		
Family members relationship				
Good relationship	328 (84.5%)	380 (83.2%)	Pearson Chi-Square /  N/S	P = .411
Fair relationship	51 (13.1%)	59 (12.9%)		
Poor relationship	9 (2.3%)	18 (3.9%)		

<sup>17</sup> Sig is a 'Significance'. In this study, the significance level (p-value) is  $\leq .05$ .

<sup>18</sup> N/s is a 'Non-significance' that is p-value is greater than .05.

Table 5.2 The association between demographic information and students' alcohol consumption behaviour				
Students' alcohol consumption behaviour	Students who had consumed alcohol  N= 388	Students who had never consumed alcohol  N= 457	Test / Significance	P value
Living arrangement				
Living with parents/guardians	360 (92.8%)	410 (89.7%)	Pearson Chi-Square /  N/S	P = .118
Not living with parents/guardians	28 (7.2%)	47 (10.3%)		
Students' monthly expenditure				
Less than 1000 Baht	123 (31.7%)	156 (34.1%)	Pearson Chi-Square /  N/S	P = .395
1001-1500 Baht	95 (24.5%)	122 (26.7%)		
1501-2000 Baht	81 (20.9%)	97 (21.2%)		
2001-2500 Baht	18 (4.6%)	21 (4.6%)		
More than 2500 Baht	71 (18.3%)	61 (13.3%)		
Students' family income				
Less than 5000 Baht	71 (18.3%)	86 (18.8%)	Pearson Chi-Square /  Sig	P = .034
5001-10000 Baht	163 (42.0%)	174 (38.1%)		
10001-15000 Baht	41(10.6%)	74 (16.2%)		
15001-20000 Baht	63(16.2%)	52(11.4%)		
More than 20000 Baht	50 (12.9%)	71(15.5%)		

From Table 5.2, findings show an association between the demographic data and the drinking behaviour. Sex and school year are statistically significantly associated with students' drinking behaviour with  $p < .001$ . Moreover, the findings also indicated that grade point average and students' family income is significantly associated with students' drinking behaviour with  $p < .05$ . The findings show that age, family members' relationships, students' living arrangements, and students' monthly expenditure are not associated with students' alcohol consumption behaviour.

### 5.11.2 The association between data relating to family members' drinking and students' alcohol consumption behaviour

Several research studies show that the attitudes of parents regarding alcoholic beverage influence young people's drinking habits (Sieving *et al.*, 2000; Van Der Vorst *et al.*, 2006). Students who live with family members who drink alcohol tend to drink (Kask, Markina and Podana, 2013).

The following table of my data shows the association between family members' drinking, the frequency of family members' drinking, and the frequency of family members having been drunk and students' alcohol consumption behaviour.

Table 5.3 The association between data relating to family members’ drinking and students’ alcohol consumption behaviour				
Students’ alcohol consumption behaviour	Students who had drunk N= 388	Students who had not drunk N= 457	Test / Significance	P value
Family members’ drinking				
Drink	384 (99.0%)	406 (88.8%)	Pearson Chi-Square /  Sig	p = .000
Not drink	4 (1.0%)	51 (11.2%)		
Frequency of family members’ drinking				
Every day	101 (26.0%)	73 (16.0%)	Pearson Chi-Square /  Sig	p = .004
Twice a week	83 (21.4%)	115 (25.2%)		
Once a week	31 (8.0%)	34 (7.4%)		
Once a fortnight	25 (6.4%)	30 (6.6%)		
Once a month	32 (8.2%)	61 (13.3%)		
A few times a year	62 (16.0%)	63 (13.8%)		
My family members never drink alcohol	54 (13.9%)	81 (17.7%)		
Frequency of family members have been drunk				
Every day	42 (10.8%)	36(7.9%)	Pearson Chi-Square /	p = .048
Twice a week	76(19.6%)	81(17.7%)		

<b>Table 5.3 The association between data relating to family members' drinking and students' alcohol consumption behaviour</b>				
<b>Students' alcohol consumption behaviour</b>	<b>Students who had drunk N= 388</b>	<b>Students who had not drunk N= 457</b>	<b>Test / Significance</b>	<b>P value</b>
Once a week	35(9.0%)	38(8.3%)	Sig	
Once a fortnight	7(1.8%)	20(4.4%)		
Once a month	50(12.9%)	54(11.8%)		
A few times a year	31(8.0%)	24(5.3%)		
My family members have never been drunk	147(37.9%)	204(44.6%)		

From Table 5.3, findings show that there is a statistically significant association between family members' drinking behaviour and students' alcohol consumption behaviour. Students who have family members who had consumed alcohol is associated with students' alcohol consumption behaviour. The findings show that family members' drinking behaviour are statistically significantly associated with students' alcohol consumption behaviour with  $p < .001$ . Furthermore, the frequency of family members' drinking and the frequency of family members having been drunk is significant for students' alcohol consumption behaviour, with  $p < .05$ .

### **5.11.3 The exploration of the association between demographic information and the frequency of students' alcohol consumption**

Within the literature there is some indication that living arrangements may be associated with frequency of drinking, as Plant and Plant (2001) found that students living independently tended to drink more frequently than those living with parents.

In this section I present the association between students' demographic data and the frequency of students' alcohol consumption. The independent variable is demographic information including sex, school year, age, grade point average, family members' relationship, students' living arrangement, family income, and students' monthly expenditure, and the dependent variable is the frequency of students' alcohol consumption. According to the assumption of cross-tabulation tests, the test is based

on the regulation that it works best when the expected frequencies are fairly large and no more than 20% of the expected frequencies should be less than five (Field, 2000). I have grouped the frequency of students' alcohol consumption<sup>19</sup> into two groups: 1) Students who have consumed alcohol more than once a month, and 2) Students who have consumed alcohol once a month or less than once a month.

Table 5.4 The association between demographic information and the frequency of students' alcohol consumption				
The frequency of students' alcohol consumption	Students who have consumed alcohol more than once during the previous 30 days  N=89	Students who have consumed alcohol once or less than once during the previous 30 days  N=299	Test / Significance	P value
Sex				
Male	50 (56.2%)	142 (47.5%)	Pearson Chi-Square /  N/S	P = .150
Female	39 (43.8%)	157 (52.5%)		
School year				
Matthayomsuksa 4	23 (25.8%)	82 (27.4%)	Pearson Chi-Square /  N/S	P = .241
Matthayomsuksa 5	24 (27.0%)	104 (34.8%)		
Matthayomsuksa 6	42 (47.2%)	113 (37.8%)		
Age				
15 years	4 (4.5%)	22 (7.4%)	Pearson Chi-Square /  N/S	P = .300
16 years	31 (34.8%)	121 (40.5%)		
17 years	25 (28.1%)	86 (28.8%)		
18 years or over	29 (32.6%)	70 (23.4%)		
Grade Point Average				
1.01-2.00	14 (15.7%)	47 (15.7%)	Pearson Chi-Square /  N/S	P = .999
2.01-3.00	45 (50.6%)	152 (50.8%)		
3.01-4.00	30 (33.7%)	100 (33.4%)		

<sup>19</sup> This variable has been grouped based on the assumption of the Cross-tabulation test



Table 5.4 The association between demographic information and the frequency of students' alcohol consumption				
The frequency of students' alcohol consumption	Students who have consumed alcohol more than once during the previous 30 days  N=89	Students who have consumed alcohol once or less than once during the previous 30 days  N=299	Test / Significance	P value
Family members' relationship				
Good	78 (87.6%)	250 (83.6%)	Pearson Chi-Square /  N/S	P = .085
Fair	7 (7.9%)	44 (14.7%)		
Poor	4 (4.5%)	5 (1.7%)		
Students' living arrangement <sup>20</sup>				
Living with parents/guardians	87 (97.8%)	273 (91.3%)	Pearson Chi-Square /  Sig	P = .039
Not living with parents/guardians	2 (2.2%)	26 (8.7%)		
Students' family income				
lowest-5,000 Baht	16 (18.0%)	55 (18.4%)	Pearson Chi-Square /  N/S	P = .203
5001-10,000 Baht	29 (32.6%)	134 (44.8%)		
10001-15,000 Baht	10 (11.2%)	31 (10.4%)		
15001-20,000 Baht	18 (20.2%)	45 (15.1%)		
more than 20,000 Baht	16 (18.0%)	34 (11.4%)		
Students' monthly expenditure				
lowest-1,000 Baht	30 (33.7%)	93 (31.1%)	Pearson Chi-Square /  N/S	P = .631
1,001-1,500 Baht	21 (23.6%)	74 (24.7%)		
1,501-2,000 Baht	15 (16.9%)	66 (22.1%)		
2,001-2,500 Baht	3 (3.4%)	15 (5.0%)		
more than 2,500 Baht	20 (22.5%)	51 (17.1%)		

<sup>20</sup> This variable has been grouped based on the assumption of the Cross-tabulation test

From Table 5.4 findings show that most variables of demographic data which included sex, school year, age, grade point average, family members' relationship, students' family income, and students' monthly expenditure are not statistically significantly associated with the frequency of students' alcohol consumption. There is only one variable, namely students' living arrangement, significantly associated with the frequency of students' alcohol consumption, with  $p < .05$ . Students who do not live with their parents (living in private accommodation) are more likely to drink than students who live with their parents. According to the literature reviews, students who live with their parents are not allowed to drink (Black *et al.*, 2008; Black *et al.*, 2010). On the other hand, students who live alone freely consume an alcoholic drink.

#### **5.11.4 The exploration of the association between family members' drinking behaviour and the frequency of students' alcohol consumption**

The literature shows that students who have seen their family members get drunk frequently tend to copy this behaviour (Assanangkornchai *et al.*, 2002; Mulvihill *et al.*, 2005). Examining the association between family members' drinking behaviour and the frequency of students' alcohol consumption, the independent variable is family members' drinking behaviour including the frequency of family members' alcohol consumption, and the frequency of family members who have been drunk. The dependent variable is the frequency of students' alcohol consumption. The following table shows the findings of the relation of these two variables.

Table 5.5 The association between family members’ drinking behaviour and the frequency of students’ alcohol consumption				
The frequency of students’ alcohol consumption	Students who have consumed alcohol more than once a month  N=89	Students who have consumed alcohol once a month or less than once a month  N=299	Test / Significance	P value
The frequency of family members’ alcohol consumption				
Every day	24 (27.0%)	77 (25.8%)	Pearson Chi-Square /  N/S	P = .305
More than once a month but not every day	38 (42.7%)	101 (33.8%)		
Once a month or less	16 (18.0%)	78 (26.1%)		
My family members never drink alcohol	11 (12.4%)	43 (14.4%)		
The frequency of family members who have been drunk				
Every day	4 (4.5%)	38 (12.7%)	Pearson Chi-Square /  Sig	P = .000
Twice a week	22 (24.7%)	54 (18.1%)		
Once a week	8 (9.0%)	27 (9.0%)		
1-2 times a month	26 (29.2%)	31 (10.4%)		
A few times a year	6 (6.7%)	25 (8.4%)		
My family members have been never drunk	23 (25.8%)	124 (41.5%)		

The findings from Table 5.5 show that the frequency of family members' alcohol consumption is not associated with the frequency of students' alcohol consumption. In contrast, the frequency of family members who have been drunk is highly significantly associated with the frequency of students' alcohol consumption ( $p < .001$ ).

#### **5.11.5 The exploration of the association between students' purchasing alcohol behaviour and the frequency of students' alcohol consumption**

Wechsler *et al.* (2002) found that students who easily access alcohol tend to drink more frequently. The purchasing alcohol behaviour is an important variable to investigate

whether it associates with the frequency of students' alcohol consumption or not. The following table will show the findings from my data analysis.

Table 5.6 The association between students' purchasing alcohol behaviour and the frequency of students' alcohol consumption				
The frequency of students' alcohol consumption	Students who have consumed alcohol more than once a month  N=89	Students who have consumed alcohol once a month or less than once a month  N=299	Test / Significance	P value
Sources of purchasing alcohol <sup>21</sup>				
Never bought alcohol	17 (19.1%)	76 (25.4%)	Pearson Chi-Square /  N/S	P = .289
Buying alcohol from a pub, bar, club, or disco	5 (5.6%)	18 (6.0%)		
Buying alcohol from non-licenced premises (community shop)	56 (62.9%)	154 (51.5%)		
Buying alcohol from a shop, supermarket or someone else bought it for students	11 (12.4%)	51 (17.1%)		
Buying alcohol from a shop, supermarket, or non-licenced premises (community shop) <sup>22</sup>				
Yes - I bought some alcohol	66(74.2%)	130(43.5%)	Pearson Chi-Square /  Sig	P = .000
Yes - I tried to buy alcohol but was refused	2(2.2%)	14(4.7%)		
No, I did not buy or try to buy alcohol from a shop , supermarket, off- licence, and I have never tried to buy alcohol	21(23.6%)	155(51.8%)		
Buying alcohol from a pub, bar, or club				
Yes - I bought some alcohol	50(56.2%)	15(5.0%)	Pearson Chi-Square /	P = .000
Yes - I tried to buy alcohol but was refused	0(.0%)	31(10.4%)		

<sup>21</sup> This variable has been grouped due to the assumption of the Cross-tabulation test

<sup>22</sup> This variable has been grouped due to the assumption of the Cross-tabulation test

Table 5.6 The association between students' purchasing alcohol behaviour and the frequency of students' alcohol consumption				
The frequency of students' alcohol consumption	Students who have consumed alcohol more than once a month  N=89	Students who have consumed alcohol once a month or less than once a month  N=299	Test / Significance	P value
			Sig	
No - I did not buy or try to buy alcohol from a pub, bar or club	11(12.4%)	34(11.4%)		
No - I have never tried to buy alcohol from a pub, bar or club	28(31.5%)	219(73.2%)		
Anyone else bought alcohol for students				
yes	45(50.6%)	57(19.1%)	Pearson Chi-Square /	P = .000
no	44(49.4%)	242(80.9%)		
			Sig	

Table 5.6 indicates that there was no association between the sources of purchasing alcohol and the frequency of students' alcohol consumption. In contrast, there is a highly significant association between buying alcohol from a shop, supermarket, or non-licensed premises (community shop), buying alcohol from a pub, bar, or club, and someone else buying alcohol for students and the frequency of students' alcohol consumption ( $p < .001$ ). This means that alcohol is very easy to obtain (buying alcohol for themselves and their group).

#### **5.11.6 The exploration of the association between family attitudes and frequency of students' alcohol consumption**

According to the literature reviews, many studies show that parents do not like it if their children drink an alcoholic beverage (Black *et al.*, 2008; Black *et al.*, 2010, Dodds

*et al.*, 2014; Assanangkornchai *et al.*, 2002). The following table shows the association between family attitudes and the frequency of students' alcohol consumption.

Table 5.7 The association between family attitudes and frequency of students' alcohol consumption				
The frequency of students' alcohol consumption	Students who have consumed alcohol more than once a month  N=89	Students who have consumed alcohol once a month or less than once a month  N=299	Test / Significance	P value
Family feelings about students' alcohol consumption				
They don't like it	47(52.8%)	171(57.2%)	Pearson Chi-Square /  Sig	P = .001
They don't mind	14(15.7%)	11(3.7%)		
They don't know I drink alcohol	20(22.5%)	82(27.4%)		
I don't know	8(9.0%)	35(11.7%)		
Family thinking to students' alcohol consumption <sup>23</sup>				
They would be upset or angry	55(61.8%)	223(74.6%)	Pearson Chi-Square /  Sig	P = .019
They wouldn't mind or I don't know	34(38.2%)	76(25.4%)		
Parents allowing students to drink alcohol at home				
Yes, always	2(2.2%)	34(11.4%)	Pearson Chi-Square /  Sig	P = .000
Yes, sometimes	33(37.1%)	50(16.7%)		
No, never	54(60.7%)	215(71.9%)		

The finding from Table 5.7 indicates a statistically significant association between the family's attitude including family feelings about students' alcohol consumption, and parents allowing students to drink alcohol at home and the frequency of students' alcohol consumption, with  $p < .001$ . At the same time, family thinking to students'

<sup>23</sup> This variable has been grouped due to the assumption of the Cross-tabulation test

alcohol consumption is significantly associated with the frequency of students' alcohol consumption with  $p < .05$ .

### 5.11.7 The association between the family members' drinking, students' friends' drinking, sources of purchasing alcohol and the frequency of students who have five or more drinks on the same occasion

Studies have shown that students who have family members who frequently consume alcohol, have friends who have drunk alcohol, and have purchased alcohol from various sources which affected them, drink more alcohol and would be a binge drinker (Nixon and McClain 2010; Wechsler *et al.*, 2002). According to the information in Section 4.4, 'five or more drinks on the same occasion' have been defined as binge drinking. In this section I want to investigate the association between the frequency of family members who have consumed alcohol, students' friends who have consumed alcohol, and purchasing alcohol behaviour and the frequency of students who have five or more drinks on the same occasion.

<b>Table 5.8 The association between the family members' drinking, students' friends' drinking, sources of purchasing alcohol and the frequency of students who have five or more drinks on the same occasion</b>							
The frequency of students who have five or more drinks on the same occasion	3-4 times or more during the previous 30 days N=38	Twice during the previous 30 days N=41	Once during the previous 30 days N=43	I have not had 5 or more drinks on the same occasion during the previous 30 days N=96	I never had 5 or more drinks on the same occasion N=170	Test / Significance	P value
<b>The frequency of family members who have consumed alcohol</b>							
Every day	11 (28.9%)	9 (22.0%)	20 (46.5%)	17 (17.7%)	44 (25.9%)	Pearson Chi-Square / Sig	P = .000
More than once a month	11	25	12	45	46		

**Table 5.8 The association between the family members' drinking, students' friends' drinking, sources of purchasing alcohol and the frequency of students who have five or more drinks on the same occasion**

The frequency of students who have five or more drinks on the same occasion	3-4 times or more during the previous 30 days  N=38	Twice during the previous 30 days  N=41	Once during the previous 30 days  N=43	I have not had 5 or more drinks on the same occasion during the previous 30 days  N=96	I never had 5 or more drinks on the same occasion  N=170	Test / Significance	P value
	(28.9%)	(61.0%)	(27.9%)	(46.9%)	(27.1%)		
Once a month or less	11 (28.9%)	4 (9.8%)	5 (11.6%)	18 (18.8%)	56 (32.9%)		
Family never drink	5 (13.2%)	3 (7.3%)	6 (14.0%)	16 (16.7%)	24 (14.1%)		
Students' friends who have consumed alcohol <sup>24</sup>							
All or almost all	16 (42.1%)	2 (4.9%)	36 (83.7%)	35 (36.5%)	65 (38.2%)	Pearson Chi-Square / Sig	P = .000
More than half	15 (39.5%)	30 (73.2%)	6 (14.0%)	22 (22.9%)	17 (10.0%)		
Half or less than half	7 (18.4%)	9 (22.0%)	1 (2.3%)	39 (40.6%)	88 (51.8%)		
Sources of purchasing alcohol <sup>25</sup>							
Never bought alcohol	4 (10.5%)	1 (2.4%)	0 (.0%)	12 (12.5%)	76 (44.7%)	Pearson Chi-Square / Sig	P = .000
Buying alcohol from a pub, bar, club, or disco	3 (7.9%)	0 (.0%)	1 (2.3%)	14 (14.6%)	5 (2.9%)		

<sup>24</sup> This variable has been grouped due to the assumption of the Cross-tabulation test

<sup>25</sup> This variable has been grouped due to the assumption of the Cross-tabulation test



<b>Table 5.8 The association between the family members' drinking, students' friends' drinking, sources of purchasing alcohol and the frequency of students who have five or more drinks on the same occasion</b>							
The frequency of students who have five or more drinks on the same occasion	3-4 times or more during the previous 30 days N=38	Twice during the previous 30 days N=41	Once during the previous 30 days N=43	I have not had 5 or more drinks on the same occasion during the previous 30 days N=96	I never had 5 or more drinks on the same occasion N=170	Test / Significance	P value
Buying alcohol from non-licence (community shop)	24 (63.2%)	29 (70.7%)	32 (74.4%)	58 (60.4%)	67 (39.4 %)		
Buying alcohol from a shop, supermarket or anyone else bought it for students	7 (18.4%)	11 (26.8%)	10 (23.3%)	12 (12.5%)	22 (12.9%)		

From Table 5.8 there is a statistically significant association between students consuming five or more drinks on a single occasion and the independent variables of frequency of family member alcohol consumption, students' friends who have consumed alcohol, and sources of purchasing alcohol. The finding shows that there was a statistically significant association between the variables, with  $p < .001$ .

#### **5.11.8 The association between students' demographic data and the purchasing alcohol behaviour**

Although there was no exploration of these variables in the literature, I tested for associations because the data in chapter seven indicated that there might be an

association between age and purchasing alcohol at the non-licensed premises (local community shops). In this section I present the association between students' demographic data, and the frequency of getting drunk of students and the purchasing alcohol behaviour. The independent variable is demographic information including sex, school year, age, grade point average, family members' relationship, students' living arrangement, family income, and students' monthly expenditure. The dependent variable is the purchasing alcohol behaviour. According to the assumption of the cross-tabulation test no more than 20% of the expected frequencies should be less than five (Field, 2000), I have grouped two variables including students' monthly expenditure and students' living arrangement as following the assumption.

Table 5.9 The association between students’ demographic data and the purchasing alcohol behaviour						
Sources of purchasing alcohol	Never bought alcohol  N=93	Buying alcohol from a pub, bar, club, or disco  N=23	Buying alcohol from non-licensed (community shop)  N=210	Buying alcohol from a shop, supermarket or anyone else bought it for students  N=62	Test / Significance	P value
Age						
15 years	3(3.2%)	3(13.0%)	13(6.2%)	7(11.3%)	Pearson	P = .476
16 years	34(36.6%)	7(30.4%)	86(41.0%)	25(40.3%)	Chi-Square /	
17 years	33(35.5%)	6(26.1%)	58(27.6%)	14(22.6%)		
18 years or over	23(24.7%)	7(30.4%)	53(25.2%)	16(25.8%)	N/S	
Sex						
Male	46(49.5%)	9(39.1%)	111(52.9%)	26(41.9%)	Pearson	P = .340
Female	47(50.5%)	14(60.9%)	99(47.1%)	36(58.1%)	Chi-Square /	
					N/S	
School year						
Matthayomsuksa 4	25(26.9%)	5(21.7%)	52(24.8%)	23(37.1%)		P =
Matthayomsuksa 5	31(33.3%)	6(26.1%)	75(35.7%)	16(25.8%)		.454

**Table 5.9 The association between students' demographic data and the purchasing alcohol behaviour**

Sources of purchasing alcohol	Never bought alcohol  N=93	Buying alcohol from a pub, bar, club, or disco  N=23	Buying alcohol from non-licensed (community shop)  N=210	Buying alcohol from a shop, supermarket or anyone else bought it for students  N=62	Test / Significance	P value
Matthayomsuksa 6	37(39.8%)	12(52.2%)	83(39.5%)	23(37.1%)	Pearson  Chi-Square /  N/S	
Grade Point Average						
1.01-2.00	10(10.8%)	2(8.7%)	38(18.1%)	11(17.7%)	Pearson	P =  .248
2.01-3.00	44(47.3%)	14(60.9%)	111(52.9%)	28(45.2%)	Chi-Square /	
3.01-4.00	39(41.9%)	7(30.4%)	61(29.0%)	23(37.1%)		
					N/S	
Students' monthly expenditure <sup>26</sup>						
lowest-1,000 Baht	33 (35.5%)	6(26.1%)	65(31.0%)	19(30.6%)	Pearson	P =  .372
1,001-1,500 Baht	19(20.4%)	9(39.1%)	53(25.2%)	14(22.6%)	Chi-Square /	
1,501-2,000 Baht	15(16.1%)	5(21.7%)	46(21.9%)	15(24.2%)		
more than 2,000 Baht	26(28.0%)	3(13.0%)	46(21.9%)	14(22.9%)	N/S	
Students' family income						
lowest-5,000 Baht	18(19.4%)	3(13.0%)	36(17.1%)	14(22.6%)	Pearson	P =  .391
5001-10,000 Baht	38(40.9%)	16(69.6%)	82(39.0%)	27(43.5%)	Chi-Square /	
10001-15,000 Baht	10(10.8%)	1(4.3%)	22(10.5%)	8(12.9%)		
15001-20,000 Baht	13(14.0%)	2(8.7%)	41(19.5%)	7(11.3%)		
more than 20,000 Baht	14(15.1%)	1(4.3%)	29(13.8%)	6(9.7%)	N/S	
Students' living arrangement <sup>27</sup>						

<sup>26</sup> This variable has been grouped due to the assumption of the Cross-tabulation test

<sup>27</sup> This variable has been grouped due to the assumption of the Cross-tabulation test

<b>Table 5.9 The association between students' demographic data and the purchasing alcohol behaviour</b>						
<b>Sources of purchasing alcohol</b>	<b>Never bought alcohol N=93</b>	<b>Buying alcohol from a pub, bar, club, or disco N=23</b>	<b>Buying alcohol from non-licensed (community shop) N=210</b>	<b>Buying alcohol from a shop, supermarket or anyone else bought it for students N=62</b>	<b>Test / Significance</b>	<b>P value</b>
Living with parents or guardians	86(92.5%)	22(95.7%)	192(91.4%)	60(96.8%)	Pearson Chi-Square / N/S	P = .504
Not living with parents or guardians	7(7.5%)	1(4.3%)	18(8.6%)	2(3.2%)		

From Table 5.9 findings reflect that students' demographic data including sex, school year, age, grade point average, family members' relationship, students' living arrangement, family income, and students' monthly expenditure are not associated with the purchasing alcohol behaviour.

### **5.11.9 The association between the frequency with which students got drunk and the purchasing alcohol behaviour**

According to the findings from the focus groups and in-depth interviews (see Chapter Seven), students who have frequently been drunk is related to purchasing alcohol behaviour, particularly buying alcohol in the Community C where the shop sellers never asked for proof of age. I therefore decided to explore any associations in the survey data. In this section I present the association between the frequency with which students got drunk and the purchasing alcohol behaviour.

**Table 5.10 The association between the frequency with which students got drunk and the purchasing alcohol behaviour**

Sources of purchasing alcohol	Never bought alcohol N=93	Buying alcohol from a pub, bar, club, or disco N=23	Buying alcohol from non-licenced (community shop) N=210	Buying alcohol from a shop, supermarket or anyone else bought it for students N=62	Test / Significance	P value
<b>The frequency of getting drunk<sup>28</sup></b>						
No, never	81(87.1%)	21(91.3%)	129(61.4%)	31(50.0%)	Pearson Chi-Square /Sig	P = .000
Yes, once	11(11.8%)	2(8.7%)	54(25.7%)	14(22.6%)		
Yes, 2-3 times or more	1(1.1%)	0(.0%)	27(12.9%)	17(27.4%)		

From Table 5.10 there is a statistically significant association between the frequency with which students got drunk and the purchasing alcohol behaviour, with  $p < .001$ .

#### **5.11.10 The association between students' demographic data and the frequency with which students got drunk**

In this section the students' demographic data and students' friends who have consumed alcohol were tested to investigate the association with the frequency of getting drunk of students in the survey. The independent variable is demographic information including sex, school year, age, grade point average, family members' relationship, students' living arrangement, family income, and students' monthly expenditure. The dependent variable is the frequency with which students got drunk.

<sup>28</sup> This variable has been grouped due to the assumption of the Cross-tabulation test

Table 5.11 The association between students' demographic data and the frequency with which students got drunk					
The frequency of getting drunk	No, never  N=262	Yes, once  N=81	Yes, 2-3 times or more  N=45	Test / Significance	P value
Sex					
Male	140(53.4%)	22(27.2%)	30(66.7%)	Pearson Chi-Square /	P = .000
Female	122(46.6%)	59(72.8%)	15(33.3%)		
				Sig	
School year					
Matthayomsuksa 4	45(17.2%)	50(61.7%)	10(22.2%)	Pearson Chi-Square /	P =.000
Matthayomsuksa 5	96(36.6%)	16(19.8%)	16(35.6%)		
Matthayomsuksa 6	121(46.2%)	15(18.5%)	19(42.2%)	Sig	
Age					
15 years	14(5.3%)	10(12.3%)	2(4.4%)	Pearson Chi-Square /	P = .009
16 years	91(34.7%)	41(50.6%)	20(44.4%)		
17 years	82(31.3%)	19(23.5%)	10(22.2%)	Sig	
18 years or over	75(28.6%)	11(13.6%)	13(28.9%)		
Grade Point Average (GPA)					
1.01-2.00	42(16.0%)	7(8.6%)	12(26.7%)	Pearson Chi-Square /	P = .003
2.01-3.00	135(51.5%)	50(61.7%)	12(26.7%)		
3.01-4.00	85(32.4%)	24(29.6%)	21(46.7%)	Sig	
Students' monthly expenditure					
lowest-1,000 Baht	86(32.8%)	23(28.4%)	14(31.1%)	Pearson Chi-Square /	P = .837
1,001-1,500 Baht	62(23.7%)	19(23.5%)	14(31.1%)		
1,501-2,000 Baht	50(19.1%)	21(25.9%)	10(22.2%)	N/S	
2,001-2,500 Baht	13(5.0%)	4(4.9%)	1(2.2%)		
more than 2,500 Baht	51(19.5%)	14(17.3%)	6(13.3%)		
Students' family income					
lowest-5,000 Baht	48(18.3%)	18(22.2%)	5(11.1%)		P = .415
5001-10,000 Baht	106(40.5%)	31(38.3%)	26(57.8%)		

Table 5.11 The association between students' demographic data and the frequency with which students got drunk					
The frequency of getting drunk	No, never  N=262	Yes, once  N=81	Yes, 2-3 times or more  N=45	Test / Significance	P value
10001-15,000 Baht	28(10.7%)	9(11.1%)	4(8.9%)	Pearson Chi-Square /  N/S	
15001-20,000 Baht	48(18.3%)	10(12.3%)	5(11.1%)		
more than 20,000 Baht	32(12.2%)	13(16.0%)	5(11.1%)		
Students' living arrangement <sup>29</sup>					
Living with parents or guardians	242(92.4%)	76(93.8%)	42(93.3%)	Pearson Chi-Square /  N/S	P = .896
Not living with parents or guardians	20(7.6%)	5(6.2%)	3(6.7%)		

From Table 5.11 the findings are that there is a statistically significant association between sex, school year, age, and grade point average and the frequency of getting drunk, with  $p < .01$ . Similarly to Section 5.11.1 some demographic data (sex, school year, and grade point average) are associated with alcohol consumption behaviour. On the other hand, students' monthly expenditure, students' family income, and students' living arrangement are not associated with the frequency of getting drunk.

#### **5.11.11 The association between the number of friends that participants have who have consumed alcohol and the frequency of getting drunk**

According to literature reviews, peer pressure is one factor which affects young people drinking. The finding of this section would confirm the reviews that students who have friends who drink alcohol tend themselves to drink alcohol (Plant and Plant, 2001; Johnson, O'Malley, and Bachman, 2001; Williams, Davies and Wright, 2010).

This section examines the association between the number of friends that participants had who have consumed alcohol and the frequency of the participants getting drunk.

<sup>29</sup> This variable has been grouped due to the assumption of the Cross-tabulation test

The independent variable is the number of friends who have consumed alcohol. The dependent variable is the frequency with which participants got drunk.

<b>Table 5.12 The association between the number of friends that participants had who have consumed alcohol and the frequency of getting drunk</b>					
<b>The frequency of getting drunk</b>	<b>No, never N=262</b>	<b>Yes, once N=81</b>	<b>Yes, 2-3 times or more N=45</b>	<b>Test / Significance</b>	<b>P value</b>
<b>Students' friends who have consumed alcohol<sup>30</sup></b>					
All or almost all	106(40.5%)	27(33.3%)	21(46.7%)	Pearson Chi-Square /  Sig	P = .000
More than half	40(15.3%)	36(44.4%)	14(31.1%)		
Half or less than half	116(44.3%)	18(22.2%)	10(22.2%)		

Table 5.12 shows that there is a statistically significant association between students' friends who have consumed alcohol and the frequency of students getting drunk, with  $p < .001$ .

## 5.12 Summary

This section presents the association between different variables from the survey which showed that some variables are associated with the alcohol consumption behaviour among young people, and some variables are not associated. The findings from the exploration of the association between different variables are very useful in encouraging me to develop the questions for the Participatory Action Research in the second phase. I checked the association of the variables and then decided to develop the concept of my schedule questions for the focus groups and the in-depth interviews. As a result of the analysis and on the basis of the literature, I was able to identify those variables to be included in the logistic regression. In the next section I will present how I selected one school for Participatory Action Research by using logistic regression, and show the variables which were to be included in the test.

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<sup>30</sup> This variable has been grouped due to the assumption of the Cross-tabulation test.



## **Part Three: The logistic regression analysis**

### **5.13 Method for Selecting a School for Participatory Action Research**

In the previous section I presented the association between different variables from the survey. My use of logistic regression draws on these findings. Having reviewed the assumptions of logistic regression, and finding it appropriate for use with the categorical data (nominal scale), I decided to use this to select one school for focus group and in-depth interviews.

A logistic regression model was used to explore which students' characteristics were given, and that it feeds into the logistical regression. The model identifies associations/factors which identify students with an increased or decreased risk of consuming alcohol in the previous 30 days. These variations in risk are expressed as odds ratios and expressed relative to a reference category, which is given a value of 1. Odd ratios greater than 1 indicate higher odds (increased risk), and odds ratios less than 1 indicate lower odds (reduced risk) (Kim and Mallory, 2014). Also shown are 95% confidence intervals for the odds ratio. Where the interval does not include 1, this category is significantly different from the reference category.

#### **5.13.1 The variables included in the model**

Previous studies in Thailand showed that demographic information including sex, school year, age, family member relationship, living arrangements, students' monthly expenditure, family income, school performance, and peer pressure affected young people's drinking (Assanangkornchai, Sam-Angsri *et al.*, 2010; Assanangkornchai, Mukthong, and Intanont, 2009; Chaveepojnkamjorn and Pichainarong, 2007). Moreover, Plant and Plant (2001) identified that living arrangements were associated with young people's drinking. Thus, in my study the model included key variables relevant to students, families and their schools which I derived from the reviewed literature. The final model was developed using an iterative process to test for significant associations. Sex, age, school year, GPA, family members' relationships, living arrangements, students' monthly expenditure, family income, and friends who

have consumed alcohol were included in all models. The variables tested in the model are listed below.

- Sex (Boys, Girls)
- Age
- School year (Matyhayomsuksa 4, Matyhayomsuksa 5, Matyhayomsuksa 6)
- Grade Point Average (GPA)
- Family members' relationship (Good, Fair, Poor)
- Living arrangements (Living with parents/guardians, Living in a cousin's house, Living with someone, Living in private rented dormitory)
- Students' monthly expenditure
- Family income
- Friends who have drunk (All or almost all, More than half, Half, Less than half, None)

### 5.13.2 Factors associated with drinking alcohol during the previous month

The following table shows the variables which were included in the test and then the p-value shows the statistical significance of the test.

<b>Table 5.13 Estimated odds ratios for having drunk alcohol during the previous 30 days (N=845)</b>					
<b>Variable</b>	<b>N</b>	<b>Odds Ratio</b>	<b>p-value</b>	<b>95% confidence interval</b>	
				<b>Lower</b>	<b>Upper</b>
<b>Sex</b>					
Boys	366	1			
Girls	479	.752	.060	.558	1.012
<b>School year</b>					
Matthayomsuksa 4	276	1			
Matthayomsuksa 5	293	1.878	.005	1.212	2.910
Matthayomsuksa 6	276	1.710	.006	1.171	2.497
<b>AGE</b>	845	1.042	.662	.866	1.255
<b>GPA</b>	845	1.340	.020	1.048	1.712
<b>Students' monthly expenditure</b>	845	1.000	.282	1.000	1.000
<b>Family income</b>	845	1.000	.668	1.000	1.000
<b>Family members' relationship</b>					
Good	708		.584		
Fair	110	.657	.368	.264	1.637
Poor	27	.744	.557	.278	1.995
<b>Living arrangement</b>					

**Table 5.13 Estimated odds ratios for having drunk alcohol during the previous 30 days (N=845)**

Variable	N	Odds Ratio	p-value	95% confidence interval	
				Lower	Upper
Living with parents/guardians	770	1			
Living with cousin's house	63	.000	1.000	.000	
Living with someone	11	.000	1.000	.000	
Living in private rented dormitory	1	.000	1.000	.000	
<b>Friends who have drunk</b>					
All or almost all	247	1			
More than half	168	.186	.000	.121	.288
Half	68	.269	.000	.169	.428
Less than half	103	.279	.000	.153	.508
Almost none	66	.447	.003	.260	.766
None	193	.478	.020	.256	.892
<b>Constant</b>		1.256	1.000		

### *Sex and age*

There was no significant difference between boys and girls. Furthermore, age was not associated with the likelihood of having drunk alcohol in the last month.

### *School year and GPA*

GPA was associated with having drunk alcohol during the previous 30 days, with an increase in the odds of 1.042. Moreover, school year was associated with drinking alcohol. Students who were studying in Matthayomsuksa 5 and Matthayomsuksa 6 were more likely to have drunk alcohol during the previous 30 days (odds ratios=1.878, and 1.710 respectively). As the finding from Table 5.2 in Section 5.11.1 showed, school year is highly significantly associated with students' alcohol consumption behaviour. The finding showed that most students who consumed alcohol are in Matthayomsuksa 5 (33.0%) and Matthayomsuksa 6 (39.9%).

### *Students' monthly expenditure and family income*

Students' monthly expenditure and family income were not associated with the likelihood of having drunk alcohol in the last month.

### *Family members' relationship*

Family members' relationship was not associated with the likelihood of having drunk alcohol in the last month.

### *Living arrangement*

Living arrangement was not associated with the likelihood of having drunk alcohol in the last month.

### *Students who have friends who consumed alcohol*

Students who have friends who drank alcohol is linked to whether or not they drank. Compared to students who have friends who consumed alcohol, the odds of friends consuming alcohol increased from 0.186 for those who have more than half of their friends who drank to 0.269 for those half of whose friends drank. The odds were also increased in the group of students who had less than half, almost none, or none of their friends who drank (odds ratios=0.279, 0.447, and 0.478 respectively).

## **5.13.3 Selecting a school for Participatory Action Research**

During the survey phase of my study, I had a chance to organize an informal conversation with the secondary school students in School E after they finished answering the questionnaires. Seven students came to me and asked why I chose this research topic. Then a conversation between me and seven students started. The students took me to a round table near the classroom where I organized the survey. The informal conversation was about the alcohol consumption behaviour of their group members. The results from the discussion encouraged me to make a decision to choose School E for my Participatory Action Research phase for many reasons. Firstly, students in this school were enthusiastic about joining the interaction. Secondly, this school was located near to the community of immigrants to Thailand where people usually drank alcohol after work. Thirdly, information from students who had participated in the conversation had clarified some of my queries for example they explained the age of drinking, source of drinking and how to get alcohol easily from

community shops. Ultimately, I cannot choose School E for my second phase because the conversation occurred by chance. I have to use the logistic regression as a tool to systematically select a school.

After I analyzed data from Schools A – H by using the logistic regression, I found that School C offered the factors most able to predict the trend of drinking alcohol. School E was the second choice to select for the Participatory Action Research.

The result from the logistic regression showed that School C had significant predictors with a Chi-square test of Omnibus tests of model co-efficient of 41.958 with p-value < .000 (Table 3 in Appendix E). Moreover, the predictors of the equation can determine the drinking behaviour of students in this school with high proportion of 81.2%. This means that the predictive ability is to explain 81.2% of the drinking behaviour. (Table 1 in Appendix E). Furthermore, the relationship of predictors and the prediction is 52.4% (Nagelkerke R square = .524) (Table 4 in Appendix E). In Table 6, every school had a chance of being selected for the Participatory Action Research; however, the predictors can predict the alcohol consumption behaviour of students in School C better than other schools in the survey. The following table shows the predictive equation for Schools A - H:

<b>Table 5.14 The predictive equation of predictors of each school</b>		
<b>School Name</b>	<b>Predictive equation</b>	<b>Nagelkerke's R2</b>
<b>School A</b>	Logit (drink) = 1.921YEAR(1) + 1.750YEAR(2) – 1.342FRIEND(1) – 1.236FRIEND(2) – 1.615FRIEND(3)	0.286 (28.6%)
<b>School B</b>	Logit (drink) = -1.917SEX(1) + 3.331RELATIONSHIP(1) – 1.939FRIEND(1) – 2.098FRIEND(2) – 2.440FRIEND(3) – 2.309FRIEND(4)	0.425 (42.5%)
<b>School C</b>	Logit (drink) = 2.227YEAR(2) – 2.460FRIEND(1) – 3.189FRIEND(3)	0.524 (52.4%)
<b>School D</b>	Logit (drink) = 1.500SEX(1) – 2.650FRIEND(1)	0.347 (34.7%)
<b>School E</b>	Logit (drink) = 1.633YEAR(2) – 2.356FRIEND(1) – 2.147FRIEND(2)	0.453 (45.3%)
<b>School F</b>	Logit (drink) = 1.878SEX(1) + 1.831GPA – 3.573FRIEND(1) – 2.262FRIEND(2) – 4.059FRIEND(4)	0.524 (52.4%)

<b>Table 5.14 The predictive equation of predictors of each school</b>		
<b>School Name</b>	<b>Predictive equation</b>	<b>Nagelkerke's R2</b>
<b>School G</b>	Logit (drink) = -1.265SEX(1) + 2.559YEAR(1) – 2.117FRIEND(1) – 1.883FRIEND(2)	0.462 (46.2%)
<b>School H</b>	Logit (drink) = -3.406SEX(1) - 3.450FRIEND(3) – 2.069FRIEND(4)	0.487 (48.7%)

## 5.14 Conclusions

In Part One of this chapter I presented the findings of the survey which was undertaken in eight schools in Petchaburi Province. The data described the characteristics and backgrounds of informants, the prevalence and pattern of students' drinking, sources of buying alcohol, money spent on alcohol, family attitudes to students' drinking, and causes of drinking.

A majority of students who completed the questionnaire were 16 years old and currently studying in Matthayomsuksa 4, 5, and 6, and their GPA was in the 2.01-3.00 range. Most participants had good relationships with their family members and lived with their parents.

Regarding alcohol consumption behaviour, just under half of 845 students had consumed an alcoholic drink during the previous 30 days; boys were more likely to drink than girls. Students usually drank a few times a year and usually drank on Fridays and Saturdays with their gangs. All or almost of their close friends were reported as having had an alcoholic drink. Beer/Lager/Cider was the most popular type of alcohol that students had drunk, followed by spirits or liqueurs.

From the survey, boys tried to get drunk more than girls, and the most common effects of drinking were 'being sick: nausea and vomiting', and 'having a hangover'. The common causes of drinking included more susceptible to alcohol use, peer pressure, and relatives' drinking.

For family attitudes to students' drinking, students were not allowed to drink at home. Students' families do not like it and feel upset or angry if students start drinking.

Furthermore, students who had ever had an alcohol drink were not likely to drink with their parents.

Part Two of the chapter presented the association between different variables which derived from data from the questionnaires. Cross-tabulation was used to analyze the association between variables. In Part Three data were analyzed to select one school for Participatory Action Research.

Data analysis shows the association between different variables from the survey. Particularly, students' demographic data is related to students' alcohol consumption behaviour and the frequency of getting drunk of students. However, students' demographic data does not associate with the frequency of students' alcohol consumption and the purchasing alcohol behaviour.

Regarding the family members' drinking behaviour, there is an association with students' alcohol consumption behaviour and the frequency of students who have five or more drinks on the same occasion but it does not associate with the frequency of students' alcohol consumption. For the family's attitudes they are statistically significantly associated with the frequency of students' alcohol consumption. Nevertheless, the frequency of family members who have consumed alcohol, students' friends who have consumed alcohol, and purchasing alcohol behaviour is highly significantly associated with consuming five or more alcoholic drinks on the same occasion.

Looking at the sources of purchasing alcohol, there is no association with the frequency of students' alcohol consumption. The other factors including buying alcohol from a shop, supermarket, or non-licensed premises (community shop), buying alcohol from a pub, bar, or club, and anyone buying alcohol for students is significantly associated with the frequency of students' alcohol consumption.

In order to select one school for Participatory Action Research as noted in Part Three, the logistic regression method was used to analyze data. Finally School C where is located in Community C was chosen because there was a high predictive ability to explain the drinking behaviour. Thus it is important to collect data from stakeholders

in Community C. I only gathered data from students and advisory teachers in School C, the other stakeholders I had to recruit from the community in which School C was located. Therefore, Community C is also included in my study site.

Findings from the survey in this chapter inform the second phase of my study which is Participatory Action Research. The findings from the survey cannot clarify the in-depth views of the participants, thus it is important for me to design the qualitative study in the second phase of my research in order to fulfil the lack of data from the survey. However, data from the survey will be used as a guide to draw up a schedule of questions for focus group and in-depth interviews. Moreover, the findings from the survey will be used to discuss the findings from the qualitative data analysis in Chapter Eight. In the next chapter I will present the qualitative methods used in the second phase of my study focused on School C and Community C.



## Chapter 6

### Phase Two: Qualitative research design for Participatory Action Research

#### 6.1 Introduction

This chapter presents the method adopted for the Participatory Action Research component of my research. This was the second phase which was undertaken from October to December 2012. The aim of this phase was to clarify in-depth the extent to which alcohol consumption by young people was a problem in one community. As described in Chapter Five, Community C was selected for further study based on the statistical analysis of the survey findings for eight schools in Petchaburi Province.

In this chapter, I describe my research approach to participatory action research in the selected study site, the participants, recruitment and access, and further details on data collection, data analysis, validity, reliability and ethical considerations.

#### 6.2 Study site for Participatory Action Research

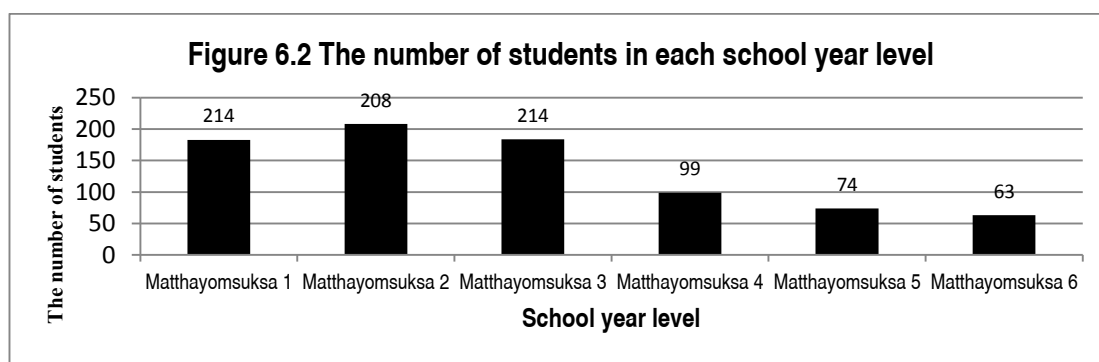


**Figure 6.1 The study site**

Participatory Action Research was conducted in School C and Community C and involved qualitative data collection from the stakeholders who had been identified as the key persons to participate in addressing the problem of young people's alcohol consumption and to develop an intervention programme. School C is located in the northern area of Petchaburi

Province. It is close to Ban Leam District, Nong Ya Plong District and Muang District. This community is in an agricultural area and near the main highway about 30 kilometres from the Petchaburi city centre. This school is close to rice fields and to a Buddhist temple. The population in Community C is around 37,855 people (18,285 male and 19,570 female): no data were available for percentages in age group. Most

residents are farmers. School C is a medium-sized<sup>31</sup> school which comprised of six levels: Matthayomsuksa 1 (Grade 7) to Matthayomsuksa 6 (Grade 12). The number of students per class is 30-45 students and the total school roll is 872. The number of students in Matthayomsuksa 4, 5 and 6 (Grades 10, 11 and 12) is 236. Figure 6.2 shows the number of students in each level.



### 6.3 Participatory Action Research (PAR)

In Chapter Three, Section 3.5.3, the Participatory Action Research (PAR) process was described as an effective research approach for the collaboration of the researcher and participants. Hence, the Participatory Action Research method is very useful for my research which aimed to explore the community's problem and to develop appropriate strategies with the people in the community. In my study, I did my research followed the first stage of PAR which was used to clarify and confirm the problem of the young people's alcohol consumption in the study site after I used the survey to demonstrate the problem. The future work of using PAR can be seen in Section 9.5.1 and 9.5.2 in Chapter Nine which is to develop the intervention programme, and then evaluate the implementation and reflect the finding to the new knowledge.

According to the 'look', 'think', and 'act' process (Stringer, 1999), which I applied to my research, the group was encouraged to observe the situation, gather information, and define the problem. In this way I was able to draw up a picture of my research and the relevant components: events, key stakeholders, location, documents, and literature

<sup>31</sup> Small school has students 1- 499, Medium school has students 500-1499, Big school has students 1500-2499 (Department of Policy, 2012)

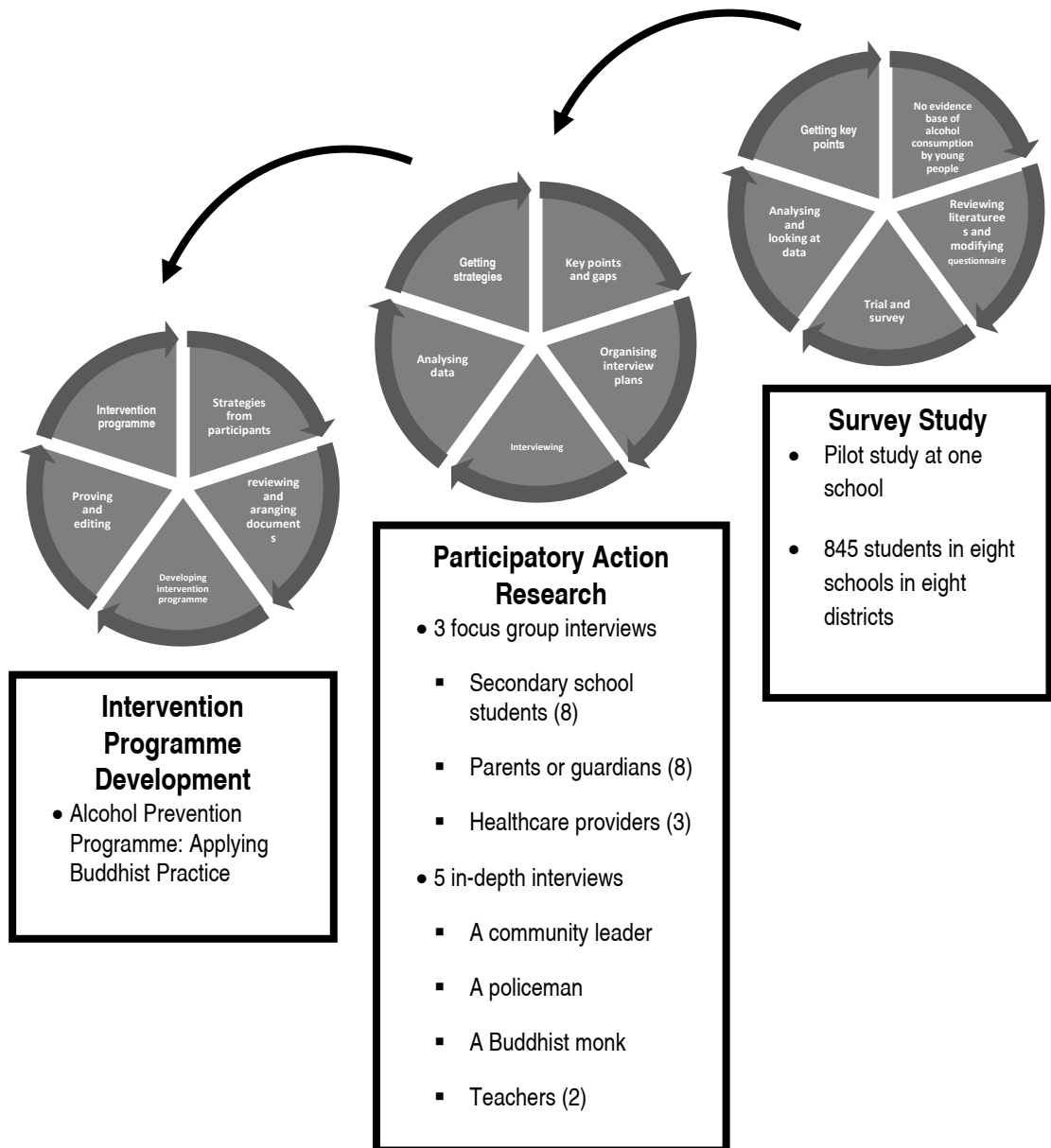
review. During the interview process, I encouraged participants to reflect on their stories and to describe their experiences during discussion. Finally the participants and I chose effective and appropriate strategies to formulate a solution to the problem in the future.

As previously discussed, the concept and the process of PAR if adopted in the second phase of my study as a quantitative approach alone would not have sufficed due to the exploratory nature of the topic. A qualitative approach was essential for exploring all avenues of enquiry in order to understand the participants' perspectives on the phenomenon of alcohol consumption by young people.

My study has three cycles (Figure 6.3). The first cycle was the survey study to clarify the problem and to understand the characteristics of young people's alcohol consumption in Petchaburi Province. As found during the literature review, there has been no research conducted about adolescent alcohol use in this area. Furthermore, several publications about young people's alcohol consumption have generally reported only at a macro level i.e. as reported nationally (national report) (Thai National Statistical Office, 2007; 2011). Therefore, in order to get a clearer understanding of the problem, I decided to study the situation at a micro level (Community C in Petchaburi Province) so as to be able to more fully comprehend the characteristics of young people drinking in this province.

The second cycle was designed to collect data from the stakeholders through focus group and in-depth interviews, following on from the survey. As described in Chapter Five, Section 5.13 the participants from School C and Community C were selected using logistic regression to participate in this study and to provide various perspectives towards young people's alcohol consumption and possible prevention strategies. At this stage, I hoped to fill the gaps in the survey data because they only provided general information about alcohol consumption characteristics and the negative consequences of such behaviour which were not sensitive to the detail of individual experience.

The third cycle, the intervention programme, will be developed, planned and piloted in Community C in the future. The research framework is shown Figure 6.3 below.



**Figure 6.3 The research framework**

#### **6.4 The participants: recruitment and access**

Focus groups and interviews were undertaken with various groups of informants where the participants were likely to share ideas with others who had the same background and therefore were more likely to be comfortable with one another (Doody, Slevin and Taggart, 2013). The participants were students, parents or guardians, advisory

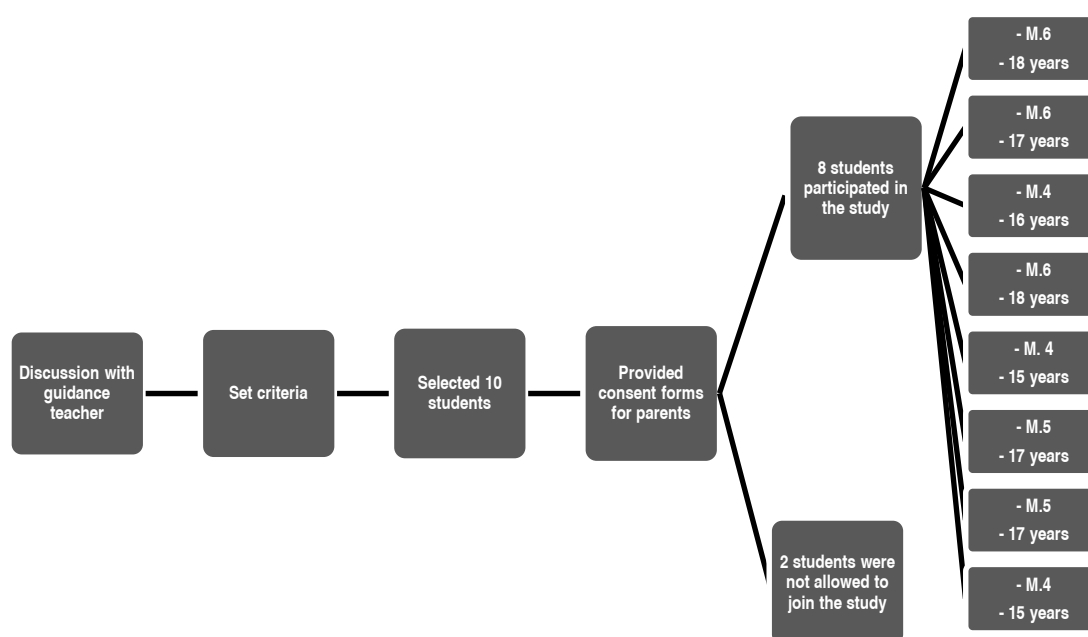
teachers, a community leader, a policeman, healthcare providers, and a Buddhist monk. The selection of the participants was based on purposive sampling techniques informed by the ecological approach which was described in Chapter Three and included the intrapersonal level (students), interpersonal level (parents), organizational level (advisory teachers), community level (a community leader, a Buddhist monk and healthcare providers), and policy level (a policeman).

#### **6.4.1 Secondary school students (High school students)**

I went to School C and met the advisory teacher and discussed with him how to select students for my focus group. The advisory teacher told me that he had all the students' document files in his office and he had records regarding students who had a record in relation to alcohol such as carrying alcohol to school (see more details in Section 4.3, Chapter Four). This provided me with ideas as how to select the participants and then I discussed with the advisory teacher how to ask students for their permission and volunteer for my study. After two days I went back to School C and met the advisory teacher for the results of asking students' permission and volunteering and he told me that students would allow me to look at their profiles and would willingly join my focus group. The advisory teacher and I discussed the criteria of all participants in detail. Finally, the agreed criteria were: 1) students had consumed alcohol at least once during the previous 30 days, 2) students were studying in Matthayomsuksa 4, 5 and 6 (Grades 10, 11 and 12) and were not over 18 years old, 3) students had to have at least one negative effect from drinking alcohol, and 4) students had to be willing to participate in the study and share their ideas with the other students. We selected 10 students from the list by simple sampling method (picked a name from the box) and all of these students were willing to participate in my study. The age of the students was 15 to 18 years old.

After the selection, I provided consent forms and clarified all details of the research in the consent form and gave students an opportunity for questions to clarify the queries. All students understood and took the consent forms to their parents or guardians and explained the details of the documents to them. After their parents or guardians got more information, they signed the consent form and returned it to me on the day of the

focus group. Following this process, there were two parents who did not allow their children to participate in my study because they did not want their children to share any information about their family's story and they did not want anyone to know about their son's behaviour. Finally, I recruited eight students for my focus group. The following figure shows the process of how I selected students to participate in the focus group interview.



(M = Matthayomsuksa)

**Figure 6.4 The recruitment process of students for the focus group**

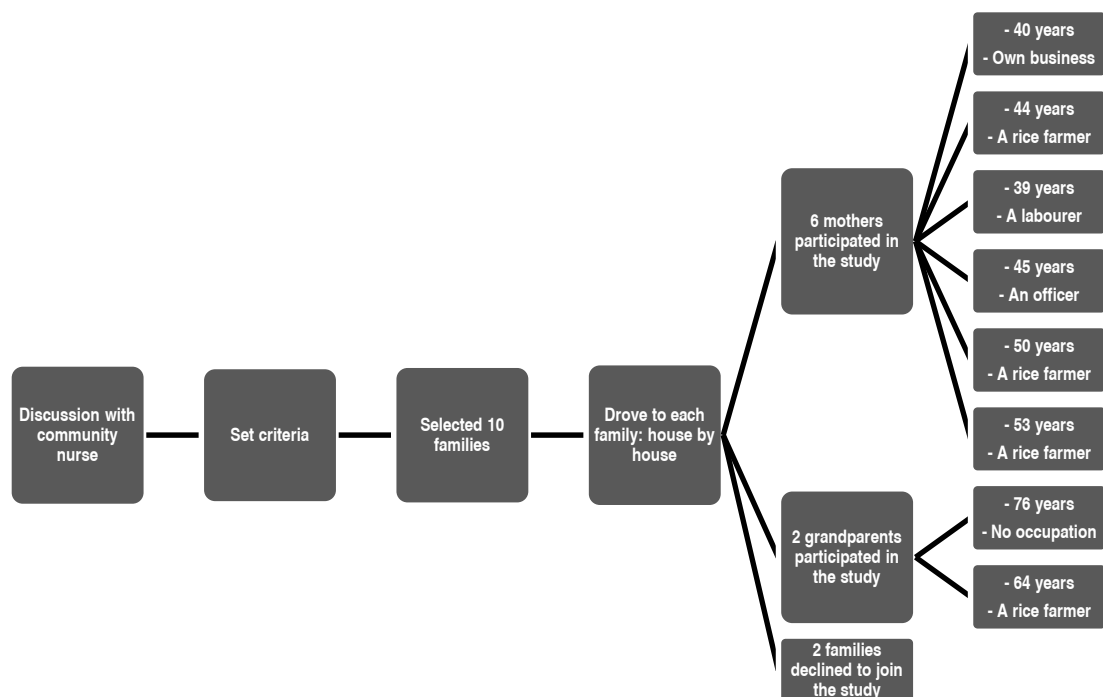
## 6.4.2 Parents or guardians

The parents' group was very complicated. At first, I had no idea how to invite parents or guardians to participate in my study because I did not know any parents who had experiences with young people drinking alcohol. Then I met the community nurse who works as a home health care worker and had a responsibility to visit patients who use drugs in the community. I discussed the matter with her and she showed me a case list which included important details of the patients in Community C. She indicated that most patients who used drugs usually drank alcohol as well. She showed me the

patients' portfolios and explained details of each patient's family profile. I got an idea from this discussion and talked with the community nurse about how to set criteria for parents or guardians who will be selected to participate in my focus groups. The selection criteria for the parents' group were: 1) parents had a child who consumed alcohol at least once during the previous 30 days, 2) the child who drank alcohol was not over 18 years old, 3) parents had experiences with young people who had at least one negative consequence from drinking alcohol, 4) parents had to be able to communicate effectively, and 5) parents had to be willing to participate in the study and share their ideas with others. Then I asked the community nurse to let the parents know about my study and my need to invite them to participate. The parents who allowed me to undertake the study were my samples.

The community nurse and I selected 10 families who had young people who drank alcohol and we drove to their houses visiting them house by house. Sometimes the parent was not at home, so the community nurse and I had to go to the rice fields to meet him/her. There was one parent who was a government officer whom I could not contact, and I had to telephone and explain the details of my study. I left the consent form for her with the community nurse to pass on.

When we met parents we provided a consent form and explained the details in the form. Then I gave the parent an opportunity to ask questions or to consult someone else such as the advisory teacher or a community nurse for further information before deciding to sign the form. I told parents to return the consent forms if they were in agreement on the day of the focus group. Four parents and two grandparents returned the forms at our first meeting while two people returned the form on the day of the focus group. However, two parents declined to participate in the study because they did not want to share their problems with the other members. In these cases I offered them an individual interview but they declined. Finally, I got eight participants to join the focus group. The following figure shows the process of how parents or guardians were selected to participate in the focus group.



**Figure 6.5 The recruitment process of parents or guardians for focus group**

### 6.4.3 Advisory teachers

The total number of advisory teachers (two teachers) were selected by purposive sampling for in-depth interview. The first one was fifty seven years old and the other was thirty seven years. They were the key people in School C to give ideas about students who had experiences with drinking alcohol. Normally advisory teachers have close relationships with students because they have roles and responsibilities to support students in many ways such as:

- To promote the expectations and aspirations to look after how students learn
- To be a source of advice for students on learning strategies appropriate for individual students
- To look after students and understand the importance of supporting learning at school



- To have lead responsibility for the development and implementation of the individual education plan within the school.

Moreover, the advisory teachers should act as a mentor who looks after students and teaches them how to adapt from being children to adults. At the same time, they help students to resolve problems for example, learning, economic and social problems. Nevertheless, advisory teachers also have to facilitate students for learning activities and guide them on how to achieve their learning objectives.

I met the advisory teachers at School C and clarified the details of my study with them and provided them with a consent form. After that I set a timetable for the interviews and they were willing to share their ideas at the school after they finished their teaching.

#### **6.4.4 Healthcare providers**

The three categories of healthcare providers: a head nurse, a community nurse and a director of the nursing school were selected to take part in my study because they are the key people to look after the young people's health particularly health promotion.

The responsibility of the head nurse is to supervise nurses working in the hospital and ensure that all nursing standards are met. She has to enable nurses in all departments to care effectively for patients. Furthermore, she has had more than 10 years' experience in an Emergency Department including the care of inebriated patients. The community nurse was responsible for looking after substance misuse patients in the community who are in rehabilitation. In addition, she works as a home health care worker and has to visit substance misusing children and their parents. The community nurse has a nurse practitioner's certificate and is a qualified psychiatric nurse. In addition, she has had experience in counselling and community care for more than five years. Furthermore, she was trained to be a project leader and programme manager in her hospital. Her most recent post was director of the nursing school. She has developed a nursing curriculum referred to as a 'Community Based Nursing Programme' designed to support the community. The nursing director collaborated with the head nurse and community nurses in order to create a health promotion

programme for young people, and in order to allow nursing students to practise their clinical skills in hospital and community.

#### **6.4.5 A community leader**

The community leader was the Deputy Chief Executive of the Petchaburi Provincial Administration Organization (PAO). He has been a Deputy Chief Executive for 22 years and had experience of the Adolescent and Drug Prevention Programme, *Dharma*<sup>32</sup> Project and working with the Petchaburi Red Cross. This project was a specific programme which the community leader said he did for a specific community. He was appointed by the President of the Petchaburi Provincial Administration Organization to give information concerning young people and their activities in the community. Moreover, he had a role in supervising all community leaders in Petchaburi Province and monitoring Community C. He also had to evaluate all the activities run by the community leaders.

#### **6.4.6 A policeman**

The Deputy Commander of the Petchaburi Police Headquarters was one of the key participants. He is a chief executive officer (CEO) who supervises all police who work in the community. He specifies policies and assigns duties to the police working in these communities such as Drink Don't Drive. He checks that their assigned duties are being carried out on a weekly basis. Moreover, he advises police personnel on strategies to resolve crime-related problems in these communities.

#### **6.4.7 A Buddhist monk**

The abbot of the Thai Buddhist temple was one of the most valuable participants in this study. In Thailand, Buddhists have the highest respect for Buddha and Buddhist monks. This monk has 11 years' experience of teaching young people and prisoners. He designs many programmes for young people and the programmes are concerned with drug abuse education and sex education. Furthermore, he has organized the drug

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<sup>32</sup> *Dharma* is the Buddha's teaching.

abuse programme with prison warders to educate prisoners about using *Dharma* to reduce stress. In addition, he teaches meditation and encourages prisoners to be aware about drug addiction and crime.

## **6.5 Data collection**

### **6.5.1 Focus groups**

I organised focus groups when I wanted detailed information about a stakeholder's thoughts and behaviours and to explore new issues in depth. As I discussed in Section 3.6.1, Chapter Three, the focus groups were undertaken with three groups of participants. Before I organized the groups I had arranged the meeting by telephoning, driving to participants' homes, and sending formal letters.

During the focus group process I aimed to obtain the perspectives of participants on alcohol consumption by young people in their community and gain a more in-depth understanding of prevention strategies. Therefore I allowed participants to say anything which they thought relevant to the topic. I did not interrupt them while they were speaking nor judge what was true or false. For my study, the focus group involved three groups- eight participants with the same background or similar experiences (e.g. students' group and parents' group) and three participants for the healthcare providers' group. My focus groups met for periods ranging from one hour and forty five minutes to two hours for each group. The duration related to the group size and the stories that participants wanted to share about their experiences.

I had carefully considered the location and time of the meetings because I wanted to provide a comfortable and suitable location and convenient time for the participants. A suitable location for participants included being convenient for transport and being held at a suitable time so as not to interrupt their study or work. I organized different places and times for each group of participants. Beforehand, I had asked participants for their best available time and place. The students' group preferred to talk at their school after they finished their classes because it was convenient for them. The healthcare providers wanted to talk in the meeting room of the school of nursing

because it was in the centre between the community and the hospital and they preferred to meet in the weekday afternoon after they finished their duties in the morning. On the other hand, the parents' group wanted to meet at the meeting room of the hospital on a weekday morning. They did not want anybody in the community to know what they did and what they said in the group session. They did not want to share their stories with anyone outside the group. I had to ensure therefore that I kept the participants' stories confidential to preserve their anonymity. Refreshments were provided to all participants during the group sessions.

Setting norms was very important for the focus groups because the participants have to respect each other in order to make the sessions run smoothly (Koch and Kralik, 2006). I asked participants to develop norms before the conversation started. Then participants considered the things that were important to them in a group environment. These were their agreed norms: only one person to speak at a time; everyone has to listen when somebody is talking about their stories; they must not embarrass anyone by laughing or expressing their views in body language; everyone has to respect each person's ideas when talking about their stories.

At the first meeting I welcomed participants at the entrance of the room and then introduced myself at the meeting table. I let participants introduce themselves and share some information about their background in order to know each other as group members and make them feel welcomed and relaxed. I started my talk with my greeting and let them know why it was important that they had joined the research, and then I followed the questions as shown in Section 6.5.3. During the conversation I kept a watchful eye on the group dynamics because I wanted to observe the emotional expressions of participants as that would help me to gain unexpected information such as when I observed that one member of the parents' group cried when she talked about her child's behaviour after drinking alcohol.

In the first instance participants did not say anything, and I had to ask them some questions to stimulate their thinking. Then the conversation was quite smooth. During the discussion participants were invited to share their stories and experiences that they faced regarding the alcohol consumption behaviour of their children. After the focus

groups I obtained much useful information from participants to organize for data analysis.

### **6.5.2 In-depth interviews in my study**

In Section 3.6.2 I described the concept of the in-depth interview. For my study in-depth interviews were useful because some participants were not able to attend the focus groups. Subsequently, in-depth interviews were used in the case of potential participants who were not comfortable talking openly in a group, and/or if the meeting time of the groups was not convenient for them. Thus, in-depth interviews were undertaken with a community leader, advisory teachers, a policeman, and a Buddhist monk to obtain insightful individual perspectives about young people's alcohol consumption. None of these participants could participate in the focus group session because of their time-consuming work. I prepared the same documents and the recorder as for the focus groups but there was no need for refreshments. More details of this process are given in Section 6.6.

The location and time of the interviews were similar to those considered for the focus groups. Participants were more likely to talk with me at their workplace. The community leader let me know that he wanted to talk with me at his office after lunch time (at noon). The policeman wanted to organize the interview at his office at 10 a.m. before he went to inspect his staff in the afternoon. The Buddhist monk needed to set the in-depth interview session at the Buddhist temple after he finished his teaching in the jail. Two advisory teachers preferred to talk with me at their school in the evening after they finished class.

At the first interview I introduced myself and let participants know why I had chosen them to join my study. Then I followed the questions as shown in Section 6.5.3. Similar to the focus group, I kept a watchful eye on participants' expressions, and observed their emotional expressions during the conversation.

My in-depth interviews and focus groups were conducted in the Thai language. Data were also transcribed and analysed in Thai language in order to ensure that the meaning of the language used by the respondents was kept intact. Translation from Thai

language into English began after the analysis had been completed and themes and quotes had been extracted (see Section 6.7). A digital recorder was used to record ideas from all participants. Information from interviewees was then transcribed using Microsoft Word software prior to the analysis stage.

### **6.5.3 Scheduled questions for qualitative data collection**

The research method for participatory action research focus groups used a semi-structured set of questions. After I had obtained the findings from the survey and literature which showed that alcohol consumption by young people related to the environment surrounding them (e.g. family, peers, school, and community), I developed a set schedule of questions (Appendix F). After that I had a meeting with my supervisors and discussed the schedule of questions required to collect information from the informants in School C and Community C. Three meetings took place for editing. Finally, the schedule of questions was complete and suitable for Thai participants in terms of culture and educational level. The final draft of the interview schedule was composed in English, and then I translated it from English into the Thai language. A set of questions (Thai version) was reviewed and approved for content validity and language editing by three experts in Thailand: the director of the Bureau of Nursing, the director of the Central Nursing Network Organisation, and a nurse practitioner.

The schedule of questions was designed for the three groups of participants; 1) Group I: advisory teacher, policeman, community leader, healthcare providers, and Buddhist monks, 2) Group II: parents or guardians, and 3) Group III: secondary school students. Each set of schedule questions consisted of five categories:

1) *Opening questions* were used to get people to feel relaxed, comfortable and familiar with talking to each other. The questions were easy to answer; and did not emphasize differences among group members. This is an example question: ‘Please tell us your name and a bit more about your background.’

2) *Introductory questions* were used to encourage participants to start thinking about the topic which also helped to focus the discussion. This is an example question: ‘What is your opinion of young people’s alcohol consumption behaviour today?’

3) *Transition questions* were used to link introductory questions and key questions. The participants were asked more in-depth questions than in the introductory questions. This is an example question: ‘What does a strategy to control alcohol consumption in young people mean to you?’

4) *Key questions* focused on the major areas of concern. Prompts were added at this stage for obtaining in-depth information or encouraging participants to think about the topic. I spent most of my time discussing these questions. This is an example question: ‘How can your community promote appropriate strategies to control alcohol consumption by young people?’

5) *Concluding questions* brought the communication to a close. This is an example question: ‘Have I managed to adequately summarise the discussions?’

## **6.6 Data collection process**

The fieldwork to collect the qualitative data was conducted from October 2012 to December 2012. Focus groups and in-depth interviews were undertaken to gain more information about the characteristics of alcohol consumption by young people in Petchaburi Province as represented by Community C. I wanted to gather perspectives on appropriate prevention strategies from the viewpoints of stakeholders in order to make recommendations.

### **6.6.1 Focus groups**

#### **6.6.1.1 Secondary school students**

Eight students who were allowed by their parents or guardians participated in this process. The selected participants were three students from Matthayomsuksa 4 (Grade 10), two students from Matthayomsuksa 5 (Grade 11), and three students from

Matthayomsuksa 6 (Grade 12) all aged from 15-18 years old. The interview was undertaken at the back of the gymnasium which was a quiet space and with nobody to interrupt the conversation. The focus group took place after students finished their classes at 4 p.m. Refreshments were offered to participants.

I commenced the process by introducing myself and participants then introduced themselves. The instructions and objectives of the conversation then followed. I started by asking the opening questions and then followed with the introductory questions, transition questions, key questions, and ended with the concluding questions. One student from Matthayomsuksa 6 was the first volunteer to answer the first question who was then followed by students from the other levels.

During the focus group meeting, students were relaxed and willing to answer my questions. Students from Matthayomsuksa 5 and 6 immediately responded to my questions while students from Matthayomsuksa 4 needed to be encouraged to answer the questions. Normally, students answered my questions one by one except some questions that they answered all together, for example, the questions about the alcohol type and when did they drink. After the conversation everyone said they felt relaxed and happy to share many ideas with group members. Nobody declined to answer any questions or left the focus group before the end of the meeting. After I had finished the concluding questions, I reflected back the main points from the conversation and left time to listen to feedback from the participants. Following the final question, I thanked all the participants for their time and contribution and concluded the meeting. In all I spent one hour and forty five minutes on meeting with the students.

#### **6.6.1.2 Parents or guardians**

This group was conducted in the meeting room in the hospital. All participants were selected according to the criteria set out in Section 6.4.2. Along with the community nurse I decided to arrange the appointment with participants using two methods. The first choice was to telephone a participant directly and the second one was to drive to their houses to give them details of the meeting. The informed consent form was provided when I met them at their houses. In one case of invitation by telephone I left



the form with community nurse to give to the parent. Participants returned the consent forms immediately after they arrived at the meeting room.

On the day of the focus group meeting, only three people came to the meeting room at the appointed time of 9 a.m. These participants and I waited thirty minutes until everyone was present. At the first meeting, eight informants talked to each other about the general topics before the interview began. Finally, the meeting proper started at about 9.45 a.m. In the meantime refreshments were offered to the participants.

After the participants were ready to start, I introduced myself and explained the instructions and aims of the focus group. After that participants introduced themselves and spoke a bit about their background. The opening questions were asked to make participants relaxed and feel comfortable about sharing ideas, and then I proceeded to ask the other scheduled questions until they had all been put to the group and discussed.

During the process, participants were likely to share their information with group members. The conversation went quite well except when I asked the question about the behavioural changes after young people drank alcohol, at which one grandmother expressed emotion. She started crying while she was sharing how her nephew drank alcohol and left school. Furthermore, she complained that her nephew sometimes swore and almost hit her with a stick. I left her expressed her emotion and carefully listened to her. Finally, two participants who sat beside her helped to soothe her, and then she calmed down and continued to participate in the conversation.

The focus group lasted two hours. I asked participants about the session at the end: everyone smiled and said that they were happy and felt good after sharing their ideas with other participants. They recommended that it was helpful for releasing their stress. Before closing the session, I gave the participants a chance to clarify questions or issues if they needed, and then summarised the conversation. Following the final question, I thanked all the participants for their time and contribution and finished the focus group.

### **6.6.1.3 Healthcare providers**

This focus group was held in the meeting room of Prachomklao Nursing College. I sent a formal letter to the healthcare providers to make arrangements for the focus group. The head nurse, the community nurse, and the director of the nursing school accepted the invitation to join the study by signing the consent form.

They came to the meeting room at 2.30 p.m. They greeted each other and started talking about their work; in the meantime, I offered them refreshments. The interview began at 2.45 p.m. with me introducing myself and providing the participants with a consent form. I explained the instructions and aims of the focus group. Then the participants read the documents and signed the forms and returned them to me. After that, the director of the nursing school introduced herself followed by the head nurse and the community nurse.

Similarly to the parents group, I started with the sequence of the schedule questions. The conversation went well and smoothly, without interruptions. Participants effusively shared many ideas with the group. Sometimes they explained their ideas by linking them to their experience of undertaking duties which related to alcohol consumption among young people. Moreover, they referenced their views to previous studies and articles in journals (Chaveepojnkamjorn and Pichainarong, 2007).

At the end of the discussion, I restated the purpose of the focus group and summarised what had been said. I left time to clarify any issues if required by the informants, and then I thanked all participants. The whole meeting lasted for about one hour and forty five minutes.

### **6.6.2 In-depth interviews**

For my study, in-depth interviews were organized for advisory teachers, the community leader, police and a Buddhist monk. First of all, these participants were to have been members of the focus group with healthcare providers, but owing to their responsibilities and in one case an unexpected accident of a family member, they could not join the focus group. The community leader and police were very busy with their

work, and the advisory teacher's brother died following an accident on the day of the interview. The Buddhist monk was teaching a class for prisoners in jail. Thus, an in-depth interview was a suitable technique for collecting data from these participants.

#### **6.6.2.1 Advisory teachers**

An in-depth interview with advisory teachers was carried out at School C. One advisory teacher was available at the reception office and another was available at his office. These advisory teachers were very familiar with my study because I had met and discussed it with them on several occasions. They helped me to set the timetable for collecting the data for the survey and gave me details about the students' alcohol consumption in this school. I started the conversation with Teacher1 at 3 p.m. in front of the reception unit. In total, I spent one hour interviewing Teacher1, and then I walked to meet Teacher2 at his office. I started the conversation with him at 4.30 p.m. and finished at 5.30 p.m.

For both teachers, the interview started right away as there was no need to introduce ourselves. I provided a consent form (Appendix D) and explained the instructions and aims of the interview, and then they read the documents before signing and returning them to me. The conversation began following the schedule of questions. Both teachers freely expressed their views about their experiences of the alcohol consumption of students in the school and young people around the school. Moreover, they gave an idea about the behaviour of alumni (former pupils) which influenced young people's drinking. At the end of the interview, I summarised the conversation and thanked both teachers for their time and contribution and concluded the interviews.

#### **6.6.2.2 A Community leader**

The interview was set up at the deputy chief executive of Petchaburi Provincial Administration Organization office at 12 a.m. He was very kind, familiar and willing to share his information. I introduced myself and provided him with a consent form. I explained the instructions and purposes of the interview (Appendix D), after which he read the documents and signed the form before returning to me.

The conversation began with general topics linked to young people's alcohol consumption in Petchaburi Province. The interview was very informative and useful. I formally started with the opening questions and ended with the concluding questions. The conversation went well but there were occasional interruptions because there were some people who wanted to meet him and needed his advice. The community leader clearly expressed many ideas which related to young people and alcohol consumption. Moreover, he supported his opinions with reference to his projects where he organised and worked with other organisations in Petchaburi Province. The conversation finished at 1 p.m.

#### **6.6.2.3 A Policeman**

This interview was undertaken at the office of the deputy commander of the Petchaburi Police Headquarters at 10 a.m. He was very friendly and willing to join my study. I introduced myself and provided him with a consent form. I explained the instructions and purposes of the interview, after that he read the documents and asked some questions about the instructions and signed the form before returning to me.

The conversation began with a general topic and linked to his job. Then he linked the questions to young people and the alcohol consumption phenomenon in Petchaburi Province. I formally asked the questions step by step and ended with the concluding questions. The interview was very formal and helpful, however, the policeman directly answered question by question. He effectively shared ideas which related to the alcohol consumption characteristics of young people in this area. Moreover, he related his views to his work and his areas of responsibility. The conversation finished at 11 a.m. but before ending I left time for the policeman to clarify any issues, and then I thanked him for his time.

#### **6.6.2.4 A Buddhist monk**

The conversation with the Buddhist monk was carried out at the Thai Buddhist Temple at 2.30 p.m. after he came from teaching prisoners in jail. He looked very tired but he was willing to participate in my study. I introduced myself and provided him with a

consent form. I explained the instructions and aims of the interview. He read and asked some questions about the instructions and the study itself, and then he signed the form and returned it to me.

The schedule of questions was used to interview him. He was very enthusiastic about answering my questions and sometimes he gave examples which related to his experiences. The interview lasted 1 hour, and then the Buddhist monk went to meet the other monks and assign them a job for a Buddhist ceremony in the coming week. The Buddhist monk effectively explored his ideas that related to my study. Moreover, he explained his projects which he organised for young people and prisoners about drug misuse. The project was intended to teach young people to refrain from drug and alcohol use, the negative consequences, and how to prevent them. Moreover, he taught young people to control themselves using Buddhist practice. The conversation finished at 3.30 p.m. It was similar to the other participants, in that I summarised what had been said and left a time to ask questions, and then thanked him for his time.

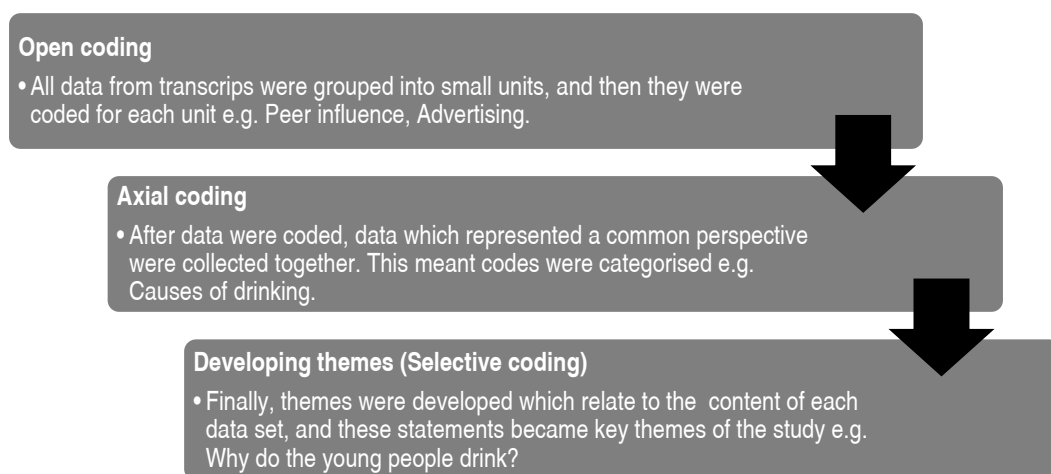
## **6.7 Data analysis**

Data analysis was undertaken in spring 2013. The interview data were transcribed using Microsoft Word and then prepared for coding and analysis by use of the computer software package NVivo 9 as discussed in Section 6.8 below. Data were transcribed and analysed in Thai language in order to ensure that the meaning of the language used by the respondents was kept intact. Hence, in this study, the analysis was carried out in Thai language, the language used to conduct the study. Translation from Thai language into English began after the analysis had been completed and themes and quotes had been extracted.

The data consisted of two sources of information. Firstly, there were the impressions that I recorded in field notes and secondly there were the digital recordings of the discussions. The information from the recorders was converted into text documents called transcripts. These were typed in Thai language, and then I had to listen to the digital recorder and check through the paper copy, following the conversation. I did this step by step, checking line by line four times. Doody, Slevin and Taggart (2013)

recommend that the data analysis consist of three stages. The first stage is open coding where all data are grouped into small units and a code is attached for each unit. The second stage is axial coding where the codes are categorised. The third one is selective coding where themes are developed which relate to the content of each data set.

This study data analysis commenced with reading a transcript and then coding each transcription (open coding). The codes linked together all the text which represented a common perspective related to the key question and the study's purpose. Then, I collected together all of the extracts from texts which had been allocated the same code (axial coding). The interpretation was the next stage (selective coding). The analytic induction technique was used to develop a summary statement which represented each extract of text in the group and these statements became the key themes of the study (Doody, Slevin and Taggart, 2013). Data were analysed by reading the narrative and assigning labels based on the meaning elicited from the narrative. This led to many initial topics being identified using a node system. I spent six weeks developing key themes for all the stages. After the analysis was completed, the tasks of reading the transcripts line by line and comparing the key themes was repeated to make sure that all codes were collected and all meanings were confirmed. Diagram 6.4 shows the coding process.



**Figure 6.6 Coding process**

## 6.8 NVivo 9

The NVivo 9 is the software package which was used as a data handling management system for data collected from the focus groups and in-depth interviews. NVivo was utilized as the analytic approach. Generally, this programme is used to refer to any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings (QSR International, 2011).

The eight transcripts (document files) from twenty four interviewees were imported into the 'sources' of data and then I coded my sources to gather material based on topics (nodes). Following initial coding, the transcripts were re-read and listened to for specific emphasis and meaning that was incorporated into the transcribed text. This aimed to find all possible data related to final themes and sub-themes (Neuman, 2006) (Figure 6.6). Figure 6.7 shows an example theme analysis using NVivo 9 programme. Main themes were highlighted. For my study, there were six themes for the alcohol consumption behaviour of young people in Petchaburi Province (Figure 6.9), and fifty-five sub-themes were clarified (Figure 6.8). The detail is presented in Chapter Seven. The following figure shows the main themes.

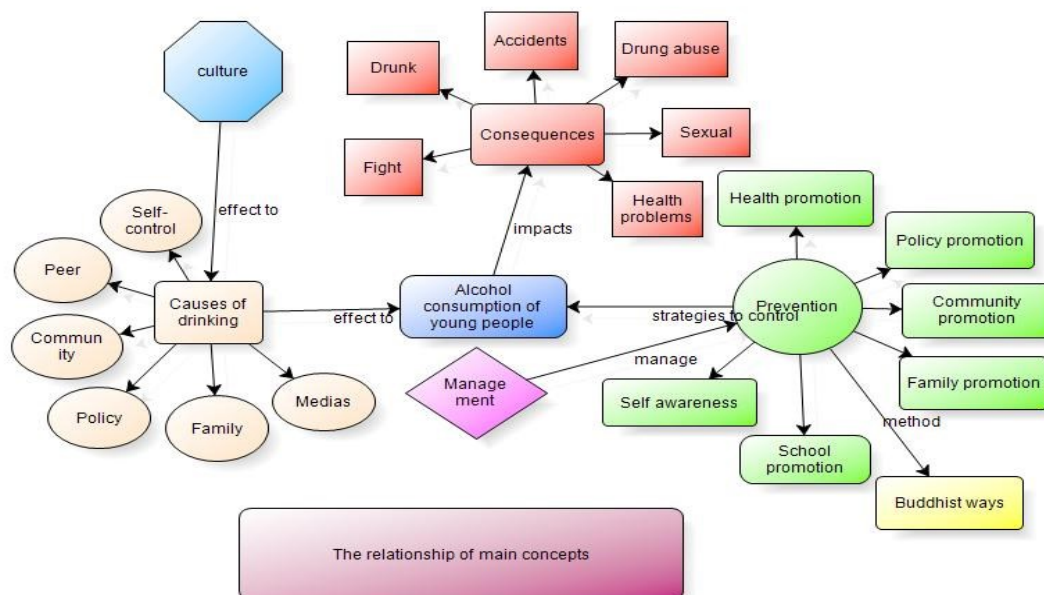
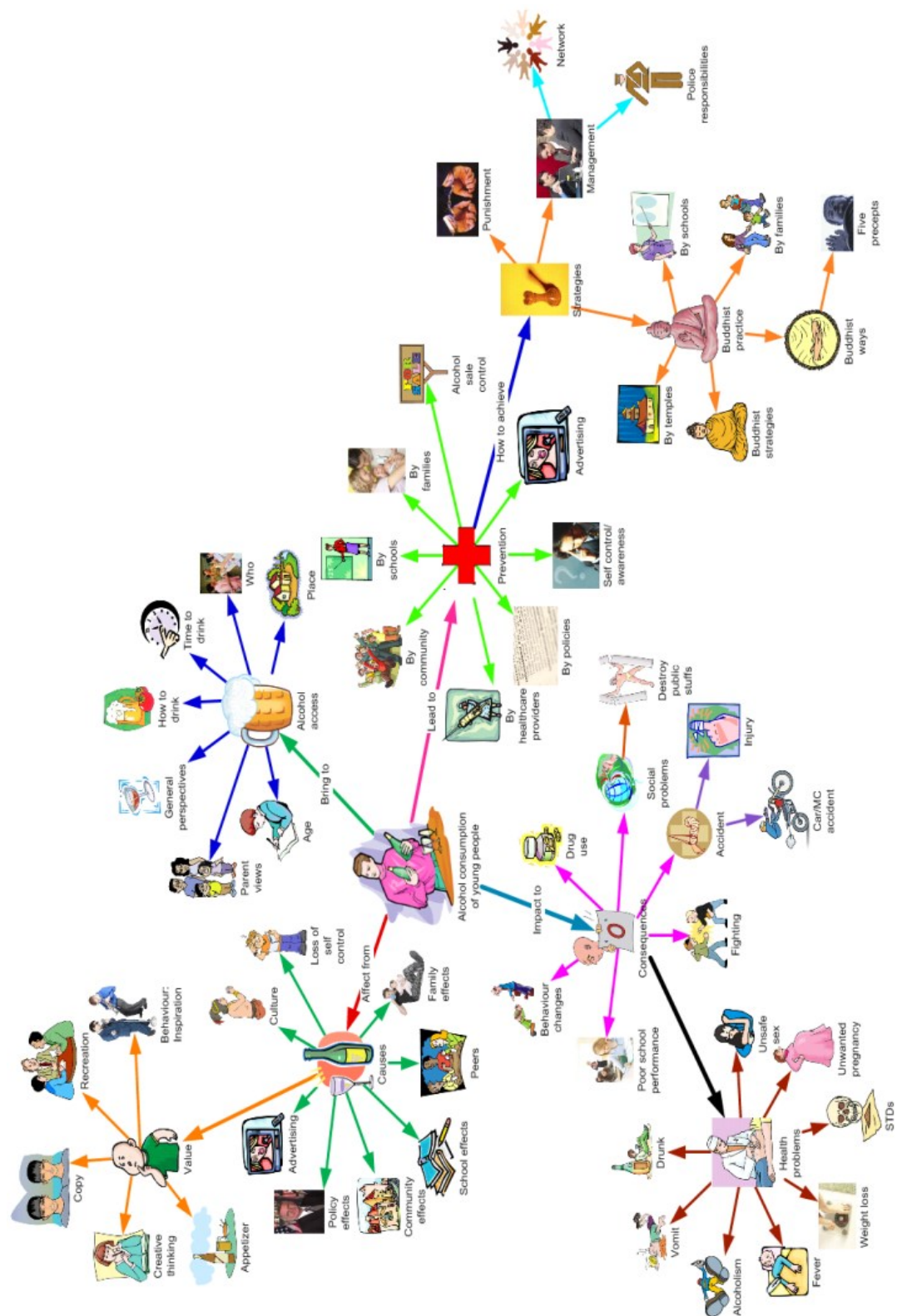


Figure 6.7 Coding from transcripts by using NVivo 9

After I had derived the main themes and sub-themes, I drew a whole picture of my study with a 'Mind Mapping' software programme which enabled me to understand the findings easily and write the report. The following figure shows the whole picture of my research findings.





**Figure 6.8 The whole picture of research findings of Alcohol consumption behaviour of young people in Petchaburi Province**

Figure 6.9 shows six themes from the findings. The six themes including Alcohol access, Causes, Consequences, Prevention, Management, and Buddhist practice. After that, themes were named as showed in the figure below.



**Figure 6.9 Main themes - Alcohol consumption behaviour of adolescents**

## 6.9 Ethical consideration

The ethical considerations for the Participatory Action Research (PAR) are similar to those for the survey which were presented in Chapter Four, Section 4.8. During this qualitative data collection stage I was also aware of ethical issues that may arise among participants during the research process. I respected the rights and dignity of the participants by strictly avoiding disclosure of any personal information about the participants (Polit and Beck, 2004; ICN, 2006; ANA, 2010). Informants' demographic data and contact details were not disclosed. The intention was to prevent the violation of personal privacy and to comply with research ethics. I notified all participants in advance of the topic, objectives, and benefits of the research project. Only those participants who agreed to contribute information to the research were invited to the focus groups or interviews.

I employed only specific codes for report writing, when recording information given by the participants. Nobody saw the raw data prior to pseudonyms or codes being substituted for names. A consent form was provided to all invited participants before

the group process took place. All participants had a chance to ask questions and request more information before they decided to join the study. Participants were informed that participation was voluntary and they were not offered any monetary or non-monetary reward. However, participants had the right to leave the group/interviews any time that they felt uncomfortable; also they did not have to answer any questions that made them feel uncomfortable. Furthermore, for students who were underage (under 20 years) and could not sign the consent by themselves, parents or guardians were provided with a consent form to consider allowing their children to participate in the study.

### **6.10 Validity of the study**

Regarding internal validity, according to the qualitative perspective, internal validity refers to the degree of accuracy of the findings in describing the realities of the phenomena of interest. Internal validity does not depend on sample size but on the richness of the information. Triangulation is one method of increasing the internal validity of qualitative studies which involved using variety of data sources (Lincoln and Guba, 1985; Patton, 2002). To enhance the internal validity of this study, triangulation of data collection methods and data sources were applied. In terms of triangulation of data collection methods, findings should appear consistent across the different data collection methods (Patton, 2002). In this study, data were collected by a survey using a questionnaire, and confirmed with data from focus groups and in-depth interviews. Moreover, some details were observed from non-verbal language and emotional expression which can support my findings that cannot be obtained by words. For example, as noted already, one guardian (a grandmother) cried while she was talking about her nephew who consumed alcohol and almost hit her with a long stick. This can tell me about her emotional distress which she was suffered from the young person's behaviour. Furthermore, for triangulation of data sources, findings should be consistent across all data sources using the same data collection method. For example, data from focus groups were collected from different group of informants, namely students, parents, and healthcare providers. Similarly, data from in-depth interviews were collected from teachers, the community leader, a policeman, and Buddhist monk.

On the subject of external validity (transferability), according to the qualitative paradigm, qualitative researchers are able to transfer their findings to other studies (Patton, 2002). Qualitative studies aim to describe the meaning of phenomena in a specific area. Transferability refers to the extent to which the findings of qualitative research can be generalized or can be used for qualitative studies in other study sites (Lincoln and Guba, 1985). Researchers can only provide the data: it is up to audiences to determine whether the findings can be applied to their own research. This study aims to describe the circumstance of young people and alcohol consumption characteristics in Petchaburi Province, Thailand. The findings will be primarily used to recommend appropriate prevention strategies for an intervention programme in the study site. The matter of the recommendations being applicable elsewhere is something that I will discuss in my thesis conclusion (Chapter Nine).

## **6.11 Conclusions**

In this chapter I have given a detailed account of the Participatory Action Research approach to the definition of stakeholders, recruitment of participants and data collection through focus groups and interviews. Moreover, I have described the details of the study site and the rationale for selection based on logistic regression. I also discussed the trustworthiness and applicability of my findings which are the qualitative equivalents of validity and reliability, the data analysis process, and ethical considerations.

I selected Participatory Action Research as the most suitable approach for phase two of the research because the findings can be used to apply and confirm the findings from the survey. Moreover, qualitative data collection can obtain in-depth information that a questionnaire alone cannot. During the focus groups and in-depth interviews I was able to obtain deeper insights into the thoughts, understanding, and beliefs of the participants. Furthermore, I could observe emotional expression and non-verbal language expressed by the informants when they answered my questions.

## **Chapter 7**

### **Participatory Action Research - Findings**

#### **7.1 Introduction**

This chapter will present and analyse the qualitative data from my research. The main themes emerging from the data are these: young people and access to alcohol, why the young people drink, undesirable consequences from drinking alcohol by young people, prevention strategies, and how to succeed with the alcohol prevention strategies. The Buddhist Practice will be described and analysed also. The themes of the research findings will be illustrated with quotations from the people that I interviewed. The source of each quotation is identified with reference to the particular interview transcript and the participant who shared their opinions with me. Some themes were raised by more than one interviewee. However, some themes were addressed from different perspectives. The aim of the chapter is to illustrate the participants' perspectives and to identify their opinions about alcohol consumption by young people. This will be followed by an interpretative analysis within a participatory research approach.

#### **7.2 The perspectives of the stakeholders toward alcohol consumption by young people in Thailand**

The participative action research focus group interviews and in-depth interviews were undertaken in order to collect data from the stakeholders in the Community C, Petchaburi Province, Thailand. The interviewees included secondary school students, parents and guardians, teachers, healthcare providers, a policeman, a community leader, and a Buddhist monk. Guardians included grandparents. The interviews took place in various places and times according to the participants' convenience. All participants were given information about the study before they agreed to participate in my research. The opening questions of the interviews were used to clarify the stakeholders' perspectives and opinions about young people drinking in Community C. The main themes which emerged from the analysis focus on the characteristics of

alcohol consumption by young people and the appropriate strategies for controlling drinking alcohol by young people. As shown in Section 6.8, Figure 6.8 and 6.9 show six themes of the findings. The sections below will clarify the details of the themes.

### **7.3 Young people and access to alcohol**

This theme illustrates the important aspects of ‘young people and access to alcohol’. The theme consists of seven categories. Each category addresses a different aspect relating to young people’s access to alcohol that emerged from the focus group data.

#### **7.3.1 Age of starting drinking**

When asked about the age that young people start drinking, all participants emphasised that young people started to drink alcohol at an early age. Alcohol was easily accessible to young people.

The director of the nursing school stated that nowadays, young people start drinking when they are 11 years old. This is very different from past generations when young people did not start drinking until they were 14-15 years old. Indeed she thought that secondary school students and undergraduate students should not consume alcohol at all because they are financially dependent on their parents. However, modern technology and communications can encourage students to drink alcohol from an early age and continuously into adulthood. The police participant also identified that young people were starting to drink at an earlier age than previous generations. Three parents who live in the same area in Community C, and who have children studying in secondary school, stated that they had seen their children drinking alcohol before they were 18 years old. They did not know when their children had first tried drinking alcohol. They said that they felt very sad when they saw their children drink alcohol. They tried to get their children to stop but the children did not respond to their advice.

The Buddhist monk supported the parents’ views. He said that students were more likely to consume alcohol before they are 18 years old and the number of young drinkers is increasing each year.

The student participants were secondary school students (Grade 10-12) in one school in Community C who knew about alcohol and had tried drinking it already. Five students knew about alcohol from seeing their fathers drink at home; the other three students stated that they had seen older boys in Community C drink alcohol. All students claimed that they had first tried alcohol when they were offered it by senior youths in Community C. The following statement from one of the students captures the group's experience:

*We started drinking when we were 10-12 years old when older boys gave us glasses of beer. At that time, we were in primary school. We didn't know what the taste of alcohol is but we see older people drink then we want to try. (Student 5)*

In contrast, one of the teachers compared this situation with his generation:

*Nowadays, young people start drinking at an early age. For my generation, we started drinking when we graduated and had a job. Another reason we started drinking late was because we were scared of our parents. We were hit with a stick if we drank alcohol while we are children. (Teacher 1)*

He indicated that young people generally drank alcohol after they graduated from the bachelor degree programme or got a job because then they could pay for the alcohol through their earnings. That is very different from the young people in this study today who have disposable income from part time employment or their parents, and access to alcohol at an early age.

The data identify a perception by participants that young people start drinking at an early age while they are still in primary school which they believe is too young to access alcohol. This perception contrasts with the past generation where young people started drinking when they were over 15 years old or graduated and had a job. Some participants made links between young people seeing their fathers and older people drinking alcohol and first trying it themselves.

### 7.3.2 Parent's views on young people drinking

The parent group commented that drinking alcohol is bad behaviour that parents do not want to see from their children. Parents will reprimand their children when they see them drinking alcohol or getting drunk but the children never obey their parents and grandparents. Several of the parents in the group agreed that:

*We parents try to teach our children not to drink alcohol but they don't obey their parents. They will trust their friends. When we say 'Stop' they never stop. In contrast, when their friends say 'Stop' they stop immediately. (Parent 1)*

One mother explained that some adults and some young people who live in Community C think that drinking alcohol is normal. Where these adults and young people do not belong to the same family, the adults do not take responsibility for suggesting that the young people avoid alcohol.

Parent 2 and the Buddhist monk suggested that it is very easy for young people to access alcohol. Young people only need to go to the small shops in Community C and buy the alcohol, and then go to another place and start drinking. Parent 2 also stated that consuming alcohol is the first thing that children want to try, and after that they want to try cigarettes and drugs. Participants in the parent group believed that drinking leads to young people taking up smoking and drug use in Community C as illustrated below:

*I saw my son, he started drinking alcohol and then he started smoking. I'm scared he will use drugs. He can get alcohol easily. (Parent 2)*

The data presented here shows that parents are concerned about young people's alcohol consumption and they try to teach their children not to access alcohol. However, their experience is that young people do not obey their parents but instead they trust their friends. The parent group believe that drinking alcohol will lead to other substance misuse.



### 7.3.3 Methods used by young people to drink alcohol

The young people were aware that their drinking was not legally permitted and they had to develop strategies to hide their alcohol or to enable them to access pubs and bars. This section describes the strategies which were identified by the young people.

#### 7.3.3.1 Method used for general drinking

All of the secondary school students stated that there are various methods used to enable them to drink alcohol but normally they drink alcohol by mixing it with sparkling soda or cold water and ice. The reason for diluting the alcohol is to avoid getting drunk. The group agreed with one student who said:

*We like to drink spirit which is mixed with sparkling soda or cold water because the taste is very nice and not too strong. (Student 6)*

They claimed that drinking alcohol with sparkling soda or cold water is more popular with boys than girls who were more likely to drink alcohol mixed with soft drinks instead.

The students said that young people in Community C do not like drinking a shot of pure alcohol because it is too strong for their throats and can make them drunk quickly; this is why they mix it with soft drink or soda/water. Also, some students added that they usually prepare food or refreshments to accompany their drinking. The students explained that:

*There is the youngest guy who mixes alcohol for us, we call him 'Kon Chong Lao'. He makes up the drinks for all group members. (Student 3, 8)*

#### 7.3.3.2 Method used to drink alcohol at the school

The teachers indicated that secondary school students sometimes drank in school during special occasions such as Sports day, New Year party, or National Children Day. Teacher 1 said that “students put alcohol in ‘Red Bull’ bottle and carry it in a school bag”. In this case, teachers did not know that it was alcohol because it looked

like the 'Red Bull' beverage and the bottle was brown. Teacher 2 explained that when students want to drink alcohol, they will put alcohol in a plastic glass and then mix it with Coke or Pepsi and ice to disguise the alcohol. He also claimed that it is common for boys to drink on these special occasions.

Although drinking in school is prohibited, the data indicate that students who want to drink will hide alcohol in their school bags disguised as soft drinks so that they can delude their teachers.

### **7.3.3.3 Methods used to get into pubs/bars to drink alcohol**

The community nurse and the police identified that young people use adults' ID cards to get into pubs and bars.

The policeman stated that in Thailand there is an Alcohol Act which does not allow people who are under 20 years old to get into pubs or bars. When he inspects pubs or bars in the city centre and checked customers' ID cards, he sometimes finds that there are young people who are underage who have used their relative's ID card to get in. The community nurse observed that young people usually borrow the ID card from their older sisters or brothers who look similar to them.

Student 8 said *"girls like to go to pubs or bars on Wednesday night because it is free entry"*. He clarified that on Wednesday nights, girls often go to pubs or bars because it is 'Lady Night' when there is no entry charge for woman. He added that girls will use their sister's ID card to present to the guards in order to gain entry. On these nights, girls will be offered drinks by men who have come to the pub or bar to look for a female partner.

In this case, the young people know that they cannot go into the pubs or bars. Therefore, they have to use an older person's ID card as a strategy to get in. However, this method is more commonly used by girls than boys.

### **7.3.4 What is the favourite alcohol for young people?**

There are many types of alcohol available in Thailand. However, in this study, the participants only recommended four types: Beer, *BLEND 285*, *Lao Pan*, and *Kra Chae*.

#### **7.3.4.1 Beer**

One of the parent participants commented that drinking beer seemed to be normal within the community. A further two parents commented that beer is very cheap and popular for young people in this community so that it is common to see young people drinking beer and riding motorcycles, or drinking beer in the evening after school. They said that the average alcohol content is 5% which is not strong enough to get young people drunk. Parent 2 claimed that young boys normally started their drinking with beer and then moved on to the other types of alcohol.

#### **7.3.4.2 BLEND 285**

The secondary school students who participated in this study said they are more likely to drink this type of alcohol, which is a whisky, than the others: “*we love BLEND 285 because it is not too expensive and looks good.*” They said *BLEND 285* is cheaper than the other spirits in this community. They were more likely to drink it because they love the smell and taste of it and furthermore, they stated that drinking *BLEND 285* was fashionable and looked high class.

#### **7.3.4.3 Lao Pan**

The healthcare providers indicated that *Lao Pan* is very popular today because it is very cheap, only 70-150 Baht (£1-3) per jug. Young people order one jug which they share between four or five friends. Moreover, the head nurse suggested that the colour of *Lao Pan* is very attractive and that it can attract students to drink it. At the same time, the community nurse commented that girls are more likely to drink it than boys because it has a low alcohol concentration, is fashionable for girls, and it looks as if

they are just drinking fruit juice; this means that parents do not know whether it is juice or alcohol.

#### **7.3.4.4 Kra Chae**

Three members of the secondary school student group talked about drinking *Kra Chae* which is an alcoholic drink produced specifically once a year for the *Sen Reun* (Ancestor worship) ceremony. They said, “*we only drink Kra Chae once a year in the Sen Reun ceremony because the smell and taste are not good. This alcohol is suitable for adults and older people*” (Students 3, 7, 8). The three students explained that young people rarely drank this type of alcohol because it is too sweet and its smell is unattractive.

The data present different reasons why young people might choose to drink the four types of alcoholic beverage. Firstly, beer is perceived as a normal drink in community C which is lower in alcohol so the young person is less likely to get drunk. Secondly, *BLEND 285* and *LAO PAN* are perceived by the young people as fashionable. *BLEND 285* is popular for boys and *LAO PAN* for girls. The last one, *Kra Chae*, is produced and consumed only for the ancestor worship ceremony.

#### **7.3.5 Where do young people drink alcohol?**

Where to drink alcohol is an important factor that can persuade young people to access alcohol. The parent group agreed with parent 1’s statement that:

*Most young people are more likely to drink in a private place. They usually drink at their friend’s house when their parents are not at home. (Parent 1)*

The students confirmed the parents’ perceptions and stated that:

*We like drinking with friends at our friend’s house particularly a friend who rents a flat or house. We don’t drink at home because our mothers usually scold us. (Student 1)*

The above information illustrates that young people are not likely to drink alcohol at their home because they might be scolded by their mothers. The young people usually

consumed alcohol at their friend's house particularly friends who rented accommodation. In the case of friends who did not rent a flat or house, they would drink when their friends' parents were not at home.

In contrast to this preference for drinking in private, Teacher 1 commented that:

*Students usually drink outside school at the weekend or after their classes. We find them sometimes drunk in school when we have had special occasions such as National Children Day, Sport Day or New Year Party.*

However, it is not normal for students to drink alcohol in the school.

The data clearly show that there are two places that young people prefer to drink alcohol. The most popular are at a friend's house and particular occasions at school.

### **7.3.6 Who do young people drink with?**

The informants expressed that there were two groups of friends that young people were more likely to drink with. This can be shown as the following information.

#### **7.3.6.1 Drinking with friends at school**

The first group who secondary school students were more likely to consume alcohol with was their friends at school. Basically, young people become part of a group of four or five people that they call a gang. This group of friends usually agree to drink alcohol at weekends. They preferred to drink with their gang because they would have the same drinking style, taste, and value. Moreover, Parent 1 supported the view that students sometimes got money from a part time job, and then they spent the money on alcohol with their friends at weekends or in the evening after school. These views can be illustrated by the following comments:

*We usually drink with my gang in school because we know each other and we have the same taste, style and value. (All students)*

*My son can sometimes earn from an extra job but he never gives me any of it because he spends it on alcohol and drinks with his friends. (Parent 1)*

### **7.3.6.2 Drinking with friends who left school early**

The second group who young people were likely to drink with was friends who left school early. In Thailand children must attend school from age seven to eighteen but this is not rigorously enforced by the authorities. Some teenagers find work, mainly in the agriculture sector after they complete Grade nine (aged 15 years). Teacher 1 explained that children like these who leave school early significantly affect other students in school. However, boys who are not in school after Grade nine are more likely to drink alcohol when they have free time and they manage to persuade students in school to drink with them. The community nurse explained to me that these children can be divided into two groups, the employed and the non-employed. The non-employed children usually drink alcohol almost every evening. In contrast, the employed children usually drink as a recreational activity and start drinking whenever they have free time particularly on Friday evenings. To support this idea, four secondary school students agreed with Student 6 who said, *“young people who no longer attend school influence us. They persuade us to drink and we cannot refuse because we are friends, so we have to do the same”*. This means that students could not refuse the offered alcohol from friends because they want to do the same things with their friends. They claimed that they cannot refuse the offer of alcohol and do not want to break their relationship because they want to be a group member.

This finding reveals that peer pressure is a significant factor for leading young people to access alcohol. Friends who are in the school are called ‘a gang’ and friends who left school early can be categorised into two groups: employed and non-employed teenagers. Both friends in the school and friends who are no longer in school can influence young people to consume alcohol.

### **7.3.7 Preferred time when young people enjoy drinking**

The preferred time for enjoying drinking is one aspect about which participants are strongly concerned. All secondary school students really recommended that they preferred to consume alcohol at birthday parties and at weekends, particularly Friday and Saturday nights. For a birthday party, students were more likely to drink because

they wanted to celebrate their friends' birthday. Moreover, they explained that alcohol was socially accepted as a pleasurable activity and for making relationships. At the same time, some students said that drinking alcohol at weekends was satisfying because there were no learning activities on the day after. Similarly, Teachers 1 and 2 said, "*young people usually drink at weekends because there is no learning activity on Saturday and Sunday*". They still stated that drinking after class in the evening was rare for secondary school students. In the same way, the community nurse added that young people who work in the factories and who think that drinking is a recreation usually drink after their work in the evening. Especially on Friday evenings, they can drink until midnight because there is no work the following day after.

### **7.3.8 Reflection summary**

This subtheme has presented data relating to young people's access to alcohol. The findings show that, in this community, the young people commonly start drinking alcohol while they are in primary school, aged 10-11 years. Surprisingly, they have various tactics to enable them to consume alcohol in school or in pubs and bars. The young people identified that drinking alcohol is a pleasurable activity, helps with forming relationships, is fashionable, and in the culture of Community C. Drinking alcohol is a social activity and young people prefer to drink at a friend's house in particular friends who rent a flat or house rather than drinking at their own house; in this way drinking is hidden from the adults. A birthday party is the favourite occasion to drink next to the weekends. Peers who left school early are influential, persuading young people to consume alcohol (peer pressure is discussed in more detail in Section 7.4.2); in contrast, they prefer to drink with their gang in school.

## **7.4 Why do the young people drink?**

This theme focuses on why do the young people drink? The findings above show that for the past generation, alcohol was normally consumed by adults who were aged over eighteen. However, this has changed for the current generation of young people who now start drinking alcohol in the final years of primary school, aged 10-11 years. My

findings reveal nine causes for young people drinking alcohol and I describe them in the following subsections.

### **7.4.1 Family effect**

All stakeholders stated that family is the most important factor affecting young people drinking particularly family members' behaviour which directly affects young people. From the focus group interviews and in-depth interviews, the participants gave me many ideas of family effect on young people as they describe below.

#### **7.4.1.1 Family members' drinking**

Most participants described the similarity between young people who drink alcohol who had been affected by the drinking of their family members. The policeman agreed with the healthcare providers who recommended that parents are particularly important as role models to their children and that families play an important part in society by teaching children to be good people. The community nurse explained, *"in Thailand, families are compared to schools and parents have a duty to teach their children about what is and is not acceptable behaviour in the home and wider community."* She added that parents teach children good manners, how to read, write, dress properly, behave in public etc. In particular, parents have to teach their children not to partake in 'bad activities' and 'illegal behaviour'. The director of the nursing school also clarified that it is very important that parents teach their children about the negative effects of alcohol; they have to lead by example and practise good activities.

However, the community nurse said that fathers often drink in front of their children which in her view sets a bad example which children and young people can copy. Similarly, the director of the nursing school's view was that previous research (Chaveepojnkamjorn and Pichainarong, 2007) stated that children who had family members who drank alcohol also tended to drink alcohol themselves. Moreover, secondary school students and the Buddhist monk expressed the same opinion as the community nurse, namely, that drinking in front of their children can set a bad example and children will copy because they are curious about alcohol and want to discover



why adults drink it despite it having negative health consequences. The participants agreed with one student who said:

*Parents say alcohol is bad but they drink as an example for young people, particularly the father. The father usually drinks and then he teaches his child not to drink. This can make children become confused. We want to copy this because we want to know what alcohol taste is and we don't know about the consequences. (Student 2)*

Similarly, the community leader's view was that children will behave by copying from their family members. He said:

*Young people's behaviour depends on their family members, if their family members are good example, they will follow. At the same time, if their family members make a bad example they will copy that too. (Community leader)*

Parent 5 who takes care of a 14 year old child gave an example to the parent group. She said that her husband had drunk alcohol almost every day from the age of 25 and he usually drinks in front of her child. Her child began to copy the father's behaviour. Parent 8 agreed with Parent 3:

*My child drinks alcohol after seeing his father drink at home. At first, he got alcohol from his uncle, after that he drinks almost every day.*

Most participants believed that family members' drinking definitely affected young people drinking, and particularly, that father and mother are the models whose behaviour young people would like to copy. Therefore, parents and other family members ought to set a good example for children including teaching young people to refrain from alcohol.

#### **7.4.1.2 Changes in family structure and life style**

Changes in family structure and life style were identified by the healthcare providers and parents group as significant. The community nurse explained that in the previous generation, children lived with their parents in an extended family and the father had a duty to work outside in the rice fields or in an office. The mother would stay at home

doing house work and teach the children. Like the director of nursing school, she suggested that “*parents and family members would spend a lot of time on teaching and training their children at home*”. She recognised that children need to learn more about the environment surrounding them, and parents have to teach them how to recognise what is good and what is bad behaviour, for example drinking alcohol is bad behaviour.

However, the participants commented that the family structure now comprises many single families that is different from the past which family members live in a big family. The head nurse said that nowadays, both parents may have to work in offices or out in the rice fields. Similarly, Parent 5 noted that parents spend much time working and earning for their family while their children are at a Child Care centre. As a result, parents have no spare time to teach their children at home. The community nurse commented:

*Teaching in the family is disappearing which is different from the previous generation when parents usually taught their children every night ... Nowadays, father and mother do not have enough time to talk and play with their children, they spend a lot of time earning and working.*

At the same time, two parents stated that school age children spend more time than ever on the Internet chatting with their friends. They asserted that this is one of the life style changes which are different from the parents’ generation when children would spend a lot of time with their parent. They added that young people do not have enough time to listen to their parents and this gap leads children to access to alcohol as they said:

*I have to work hard in the rice field and have not enough time to teach my son because I don’t meet him when I came back from work. I don’t know what my child needs, he only plays with the computer. Sometimes we never talk to each other. (Parent 5)*

*When my son finishes his school, he usually spends a lot of time in his room and surfs the Internet. (Parent 8)*

The community leader said that the young people will have good manners if they have a warm family and good examples. In contrast, young people will access alcohol if

their live in an unhappy family. This view is supported by Parent 2 who has a child with her and defined herself as an ‘unhappy mum’:

*I cannot teach my son to avoid from alcohol because he doesn't listen to me. In contrast, he obeys his friends more than my teaching...his behaviour makes me unhappy and feeling weary.*

Another aspect of the family effect is ‘the broken family’ which was defined by Parent 1. She wept as she explained to me, “*broken family is an important point affecting young people drinking*”. She clarified that ‘Broken home’ is where one parent is no longer part of the family, through death or separation. When this happens, the pressure or depression can contribute to the reason for young people turning to alcohol. When the parent divorce, children struggle to cope and don’t know who to turn to when they have problems. She explained that:

*My child's mother and father were divorced and nobody took interest in him. Though, he spends a lot of time with his friends, particularly friends who do not attend school. (Parent 1)*

Moreover, she told me that a separated single father or mother may be struggling financially as well as being mentally stressed or depressed. They may not have enough time to take care of their children, and will drink a lot to forget about their worries and sadness. She gave an example from her own family: “*after my great nephew's mother separated she did not have enough time to care for her child, she drank a lot and always on the phone to her new boyfriend.*” This would set a bad example and the children may end up copying their parents’ bad habits.

The findings illustrate the participants’ perspectives of family effects on young people drinking. In Thailand, people believe that family is the most important source of teaching children to be a good person. Parents are role models for children. They have to teach and provide a good example for children. If parents drink alcohol in front of their child, the child will copy this habit. In contrast, if they teach the negative consequences of alcohol and do not drink, the child will refrain from alcohol. At the same time, changes in family structure are a factor in leading young people to access alcohol. The changes in family structure and life style from extended family to single family affect young people’s drinking. Parents work hard and have no spare time to

teach their children, and broken homes, and Internet addiction can lead young people to access alcohol as the above perspectives show.

### **7.4.2 Peer effect**

Peer effect is an important factor in young people drinking (Williams, Davies and Wright, 2010). My research informants divided peers into two groups; peers in school and peers who left school early. However, both groups are said to affect young people to drink alcohol in different ways as will be explained in this section.

#### **7.4.2.1 Peers in school**

Most students reported that they started drinking after being offered alcohol by senior students in the same school. They agreed with Student 3 who mentioned: *“we started drinking when we finished primary school, by older students offering us alcohol”*. They also commented that the first time they only sipped, and then they were shown how to mix alcohol and consume it in numerous ways. Student 1 agreed with Student 2 who stated that they cannot refuse alcohol from the seniors because the seniors are older and therefore juniors have to respect them. Student 4 quoted a newspaper article which said that the juniors have to respect to the seniors, and if they do not respect the seniors, they can be attacked by them. Student 4 insisted that

*If we don't accept the seniors' alcohol, they will revile us. You can read in the newspaper that shows you the fighting between students in the same college who didn't respect the seniors. (Student 4)*

Teacher 1 said: *“The Alumni Association party is a cause of young people drinking. The alumni usually offer a glass of alcohol as refreshment. Because of their fear of senior students, younger students will drink and it is linked to a new school culture in Thailand”*. He also commented that offering alcohol by the alumni is a new trend in Community C. On this occasion, the school officers organized the party and invited all alumni and current students to join. The party usually takes place at night. In this case, the alumni would offer alcohol to students who joined the party and young people could not refuse.

#### 7.4.2.2 Peers who left school early

The participants expressed the view that peers who left school early can be effective in persuading young people to consume alcohol. The community leader supported this and commented that young people who no longer attend school influence former friends who are still there. They persuade the students to drink and the students cannot refuse because they are friends, and so must do the same. The students claimed that if they refuse alcohol, they will not be accepted as a group member and can be assaulted. The group agreed with Student 6 who said:

*Young people who are uneducated influence us. They persuade us to drink and we cannot refuse because we are friends and want to do the same. Normally, these friends who no longer attend school are more likely to drink than students in school. We are scared if we aren't in the group, we will be assaulted. (Student 6)*

Parent 6 expressed her view that normally, children who are uneducated are more likely to drink alcohol than students in school and usually meet and start drinking alcohol almost every evening. She said: *"today children are not concerned about bad behaviour; they need to do the same as their friends"*. The community nurse also indicated that uneducated friends who work in the factories usually drink alcohol for recreation at weekends and they can spend some of their earnings on their friends' alcohol consumption.

Teacher 1 described how there are many children who left school early in Community C and can lead students still in school to access alcohol because the uneducated children like to drink in their spare time. He commented that children who left school early affected students still in school and they cannot organize anything for them:

*Uneducated children significantly affect other students at school. They can persuade students to drink alcohol outside the school. We cannot teach those who have left school early because they do not come under our supervision. (Teacher 1)*

In summary, peers are the key people in persuading students in school to consume alcohol, particularly peers who left school early. Students in school usually drink with

a gang in school at birthday parties or weekends while peers who are uneducated usually drink whenever they have spare time.

### **7.4.3 School effect**

The school curriculum is one factor which indirectly affects young people's drinking. Students and teachers believe that the important strategy for controlling alcohol consumption by youth is the effectiveness of health education at school. Students and teachers are concerned about the subject of health promotion. Teachers recognised this subject as promoting good health and as teaching about to prevent diseases and substance misuse. Teacher 1 agreed with Teacher 2 who explained that there is insufficient time for teaching about health promotion in school:

*There is the topic of Alcohol Prevention in the lesson plan but there is only one hour to teach it. There is a lot of content to promote young people's health; however, most teachers are concerned more about drug addicts than alcohol consumption. Truly, alcohol consumption is the cause of drug use or unsafe sex. (Teacher 2)*

Similarly, the student group complained that there is not enough time set aside for teaching secondary school students about the impact of alcohol effects. There is only one hour per year for such teaching and it is too late to teach secondary school students about alcohol consumption because the students start drinking while they are in primary school. Furthermore, the Buddhist monk said: "*sometimes teachers teach the students to avoid alcohol but they themselves drink in the evening when they finish their work*". This suggests that teachers' own behaviour is providing an example that students copy.

To summarise, teaching in school is perceived as a significant method of preventing students from consuming alcohol, but the curriculum has to fit the educational level and daily life in order to provide knowledge for students about how to refrain from drinking alcohol. In the case of alcohol consumption by young people, it is suggested that such teaching should be provided in primary school.

#### **7.4.4 Community effect**

Drinking alcohol is prevalent and socially acceptable as a legitimate and pleasurable activity in Thailand. In this subtheme I shall present the community effect on young people drinking under two categories.

##### **7.4.4.1 Young people drinking as an effect of adults' drinking**

The community leader noted that adults in Community C think it is acceptable behaviour for Thai men to drink alcohol anywhere and this seems a norm in the community. He pointed out that adults commonly drink alcohol wherever it is available, for example at a wedding party, ordination ceremony, birthday party, or after work. Similarly, in the community nurse's opinion adults' drinking becomes an example for young people to copy: *"adults in the community are not concerned about young people drinking. They think this is normal"*. Comments from students and teachers showed that young people believe drinking alcohol is normal for Thai men. An important point with which most students agreed was made by Student 3: *"there is no regulation to say young people cannot drink in Community C"*. This is especially true at parties when the adults allow or offer alcohol to young people. The community nurse further commented that *"most adults in Community C are not concerned about the negative effects of alcohol consumption for young people"*. She said the adults consider it to be normal behaviour and anyway they are still in good health.

##### **7.4.4.2 Young people buying alcohol from community shops**

The community shop (grocery) is one factor which can lead young people into easy access to alcohol. Most participants stated that it is very important to be concerned about the community shops. The head nurse noted that there are many community shops in Community C where young people can easily obtain alcohol. Like the parents, they complained that there are many community shops open 24 hours a day and children can buy alcohol at any time. Like the Buddhist monk's and the community nurse's view, participants described one cause of young people being able to drink is that they are innocently sent by a family member to buy alcohol from the community

shop for older family members. The first time, the seller will challenge them and ask why they are buying alcohol. Children will tell the shop keeper that it is for their parents. If the shopkeeper accepts this explanation as legitimate then he will probably sell the alcohol to the young person. Student 6 pointed out that “*the shop owners do not ask children for the ID when they buy alcohol*”. Students 3 and 5 reported that on subsequent visits the seller may not challenge the children nor checking their age, and there is no police inspection of the shops. Thus young people can obtain alcohol for their own consumption. Moreover, Students 7 and 8 stated that in Community C, the young person’s familiarity with the shop owners allows them to easily buy alcohol from the community shop without an ID card check:

*Most shop owners in the community sell alcohol to children. They never ask for ID although they know the age of the buyers is less than 20 years. We can buy alcohol because we are familiar with the owners and we used to buy alcohol for our parents. (Student 7)*

However, the community nurse agreed with the community leader who commented that the shop owners do not care about the consequences of alcohol drinking in young people. They are more concerned about making money than the negative effects on children. To support this view, the Buddhist monk recognized that children do not buy alcohol in the supermarket because there are CCTVs in that shop and the shopkeeper is scared to sell alcohol to them. Buying alcohol in a community shop is easy because the shop owner does not care about the age of buyers and there is no CCTV to capture the evidence.

The findings showed the community is the place where many people live together. The environment around the community can be the cause of negative behaviour, for example, adults’ drinking alcohol and offering alcohol toward young people, including selling alcohol by the owners of community shops. It seems that everyone in Community C can be a factor in leading young people to obtain alcohol. This has implications for policy development regarding access to alcohol.



### 7.4.5 Policy effect

The head nurse complained that the policy makers- the politicians and the provincial authority - have formulated The Alcohol Act but do not enforce it. She said that the policemen are the key people to take action by inspecting alcohol control throughout Petchaburi Province, but the action is not consistent. The Police usually take action only at special festivals and the policy makers never check that the policies are being carried out.

The police officer complained that there are insufficient staffs for monitoring whether the Alcohol Act is complied with in Community C. Some police departments have set inspection control points but these do not cover all areas in Petchaburi Province. He said:

*Regarding Blood Alcohol Control by breath analyzing; we tend to be restricted to vehicle drivers. This is because it is easy for motorcycle riders to escape the police who man the control points.  
(Policeman)*

Besides, the police officer claimed that although they directly control the licensed shops, minimarts and shops within petrol stations, they cannot cover all the smaller shops in the community because there is not enough staff to regularly inspect them all.

The head nurse seemed to be dissatisfied with how the policy works. She commented that there is no effective anti-drinking alcohol campaign in this country. She said: *“there is no putting the negative effects on the packaging as happens with cigarette packaging”*. She also noted that the anti-drinking alcohol campaign is organised only on special occasions such as New Year’s Day or *Song Kran* (Splashing Water festival). These campaigns are focused on preventing drink-driving and deaths from accidents. That is not consistent with promoting a health message and educating young people to avoid drinking alcohol altogether, or if they do drink, to do so responsibly.

Moreover, according to the head nurse there are no government restrictions on the type of sponsor or advertisers at stadiums and sporting events. She complained that *“alcohol companies are the main sponsors of sports competitions and there are lots*

*of pictures of alcohol brand names around the sporting arenas”* and that the companies supply alcohol for the winning celebrations. This leads the sportspersons and supporters, who are mostly young people, to accept this behaviour and usually use alcohol to celebrate winning.

Student 6 who is the representative of the student group reported that buying alcohol in the community shop is very easy and that no policemen check on him. He said that the police do not really take action. They only take action in the city centre by checking alcohol sales in pubs and bars, but not in community shops. He stated that children can access alcohol easily and without punishment. As he described:

*The policemen do not really take action, I never see the police officer punish the shop owners when they sell alcohol to young people. It's only a saying but no action. (Student 6)*

In summary, the participants shared their opinions towards the Alcohol Policy as a main tool to control alcohol consumption in Community C. They show that if there is no serious action on the policy implementation, it can be the opportunity for young people to access alcohol. Therefore, everyone has to follow the Alcohol Act and the policemen have to enforce the policy into the community. If the community members such as community shop owners and pub or bar managers break the law, and there is no effective anti-alcohol campaign, it will lead young people to access alcohol easily.

#### **7.4.6 Advertising**

Alcohol advertising can persuade customers, particularly young people, to access alcohol. The community leader explained that the rapid growth of technology has exposed more people, regardless of age, to advertisements promoting alcohol, particularly with online advertising. Teacher 1 commented that children are exposed to online media alcohol advertising: *“Today students spend a lot of time on the Internet. They feel very confident to do everything by searching on the Internet. Also, students are addicted to games. Alcohol consumption advertising reaches them through online media and they want to copy”*.

Similarly, the director of the nursing school described how children see alcohol for sale on websites, and famous celebrities and pop stars drinking alcohol via online films or video clips. These influence children and they want to try alcohol. In addition, the Buddhist monk complained that the young people are rapidly reached to modern technology and this can lead young people to access alcohol.

In this section, I illustrated how informants' attitudes towards advertising was very influenced by daily life and was based on their experiences in their occupations. They indicated that people could gain access easily to advertising in particular online advertisements. Alcohol advertising in various media could be a factor in drinking alcohol by young people because young people wanted to try and copy what they see in advertisements. In particular, there were favourite actors/actresses who were role models.

#### **7.4.7 Loss of self-control**

This section describes how young people consumed alcohol because of their loss of self-control. Student 3 talked about the loss of self-control that young people saw in the adults who usually drink alcohol and they wanted to know what it tastes like and why the adults liked to drink. He explained that young people did not have the critical thinking to consider whether drinking alcohol is good or bad for health, and they did not restrain themselves from drinking alcohol. The community nurse agreed with Student 3 and she also reflected that children only wanted to copy adults' behaviour because they thought that it was accepted by people in the community. That is similar to Parent 4 who said:

*Children do not know what the example of good behaviour is which they want to copy.*

However, the community nurse still talked about the significance of the background of young people who drank alcohol and its effect on their decision making:

*Drunk students usually come from poor backgrounds and are not trained in good behaviour; in contrast, good students usually come from a good family and have been trained in a good manner to think whether alcohol is useful, or poisonous. (Community nurse)*

Similarly, Student 3 discussed how some students stay in private accommodation or at a friend's house which makes it very easy to persuade them to access alcohol because these children do not have enough knowledge about how to refuse alcohol offered by their friends, and sometimes they used alcohol to relief the distress from grief loss, broken heart, loneliness and encouraging self-efficacy. On the other hand, the community leader explained that good students would have critical thinking skills because they would be encouraged by their parents and would be able to decide that alcohol is poisonous and restrain themselves from consuming it.

Thus there are perceptions that loss of self-control is a factor leading young people to consume alcohol. Children who have no self-control and do not have critical thinking will not know what suitable behaviour is. Also, they cannot decide to prevent themselves from alcohol consumption. At the same time, young people who come from poor backgrounds and do not live with their parents can be easily persuaded to access alcohol because they are not trained in critical thinking skills and how to refuse alcohol.

#### **7.4.8 Culture**

##### **7.4.8.1 The community culture**

One of Thailand's cultural characteristics is that of gratitude. As the result of comprising various cultures, there are many ceremonies in Thailand, such as *Sen Reun* ceremony in Community C. The head nurse indicated that culture is a factor in young people's drinking. This is similar to the community nurse's attitude who said that:

*Thai people usually use alcohol in cultural and religious settings and then they drink that alcohol because they believe it bring them luck.*

Similarly, three students said: *"there is a typical culture in our community that is called Sen Reun. It is an annual traditional ceremony and people make a local alcohol"*. They claimed that people in community C have paid respect to the 'Ancestor ghost' and celebrate 'Ancestor worship'. On the occasion of *Sen Reun*, people will

make a local alcohol called ‘*Kra Chae*’ and adults commonly drink it and allow young people to drink it as well.

The head nurse commented on celebrations of winning:

*Alcohol is used as a symbol which presents the winner of the sports competitions and generally available to the watching public.*

She also indicated that the sports players always used alcohol for the celebrations, thus exposing children to this behaviour and making them prone to copy it. She said that it appeared to be a new cultural phenomenon in Thailand for sports players to use alcohol as the main way to celebrate winning.

In this section, culture is a norm and living style of the people in the community. Adults in the community are the key people as a role model of young people as new generation to copy. This means culture which reserved by the elderly can be reached to young people in these days to follow because they think that is an important thing to do as their parents did, for example, drinking alcohol in ancestor worship is good for life and makes people lucky. This activity exposes young people to start drinking when they are childhood and subsequently heavy drinking when they are growing up. The new culture is about the winning celebration by using alcohol and this can lead young people to copy the sports players’ doing.

#### **7.4.8.2 New generation belief**

Belief is an important factor that leads young people to access alcohol. In addition, the beliefs of young people are different from those of the previous generations. Students 2 identified alcohol as the way to be a strong man and brave:

*Young people try to drink alcohol because they think it can make them strong men and be brave to do things that they could not do before, for example, the young people can say ‘I love you’ to their girlfriends after drinking. (Student 2)*

He believed that if young people did not drink alcohol, they could not do anything. Besides, the head nurse said: “*some students believed drinking alcohol is a ‘Right of passage’ to adulthood*”. She said this belief commonly occurred with secondary

school students who want to be adult and drink alcohol. This is similar to the policeman's view. He said: *"some students copy drinking alcohol from actors on TV programmes or films which they believe a smart behaviour and attractive"*. He spoke of how children wanted to be smart and attract other people.

However, Student 4 and Student 6 agreed with the community nurse that some children believed that drinking alcohol is a recreational activity. Particularly, young people who work in factories usually drink alcohol after their work because they want to relax. At the same time, the community leader stated that some children believe drinking an appetizer before a meal is good for health and that vocational students believe that drinking alcohol can make them more creative and artistic in the work they produce:

*Some children are more likely to drink before meal as the adults do because they think it is good for health. Once, I have talked with the vocational students. Some students do not want to drink but they drink because it can make them more creative. Normally in art school, students say 'I can draw a beautiful picture after I get drunk, and my works will be admired by the customers. (Community leader)*

In this aspect, participants showed that misunderstanding of the value can lead young people to access alcohol. Therefore, young people have to be encouraged to understand of the appropriate value. If they get a good value, they can prevent from drinking alcohol.

#### **7.4.9 Reflection summary**

During my research within the community, I found that there are many reasons for young people drinking alcohol. These include

- Family life influencing young people's behaviour
- Peer pressure from friends, fellow students and wider social trends
- Neighbourhood community shops selling alcohol without regard to age limits
- Insufficient resources for teaching health education and alcohol awareness within schools
- Government policy and the inconsistent enforcement of the Alcohol Act across the region

- Marketing and alcohol advertising reaching and influencing an increasingly younger audience
- Young people drinking alcohol to boost confidence or relax when stressed
- It is now becoming culturally acceptable to drink for many celebratory reasons. Previously it was only acceptable on religious or traditional holidays
- Drinking is seen by some as a positive attribute, macho, sophisticated and modern

Young people are individuals and are all unique through their upbringing and education, whether they are from the village or city and whether they are students or have to work. Their needs and how they cope with the pressures or pleasures of adulthood is different in every case. They will all be open to temptation and have had numerous opportunities to drink alcohol as they progress towards adulthood. All the reasons listed above can have a cumulative effect and lead to young people drinking at an early age and making them vulnerable to getting into trouble or being at risk of long term detrimental health effects.

## **7.5 Undesirable consequences from drinking alcohol by young people**

It is not surprising that there will be negative consequences for young people from drinking alcohol. The research informants had a variety of opinions about this, as described in the following section.

### **7.5.1 Accidents**

Accidents were the first negative consequence mentioned by participants when asked what the consequences of drinking alcohol are. In this subtheme, the police officer stated that statistics showing alcohol as a cause of accidents had shown a rapid increase this year (2012), particularly accidents involving motorcycles. He said: *“accidents have rapidly increased in Petchaburi Province, and the young people like to travel on motorcycles. I found that young people who had an accident usually had drunk alcohol and got drunk”*. He added that young people who got drunk like to ride motorcycles on the main streets not only to travel home but also to race. As a result, they have an accident. Similarly, the community leader agreed with teachers who stated that young

people were more likely to ride motorcycles after drinking because they are impetuous and think that this activity is fun. The community leader added that the consequences of the accident were injury, disability, or death.

Moreover, the director of nursing school agreed with the head nurse and the Buddhist monk who commented that young people have accidents as a result of being drunk because they cannot ride motorcycles carefully. This can best be described in the following views:

*I have experience at the Emergency Department, when adolescents usually came to hospital as a result of an accident. In 90% of these cases the adolescents were drunk. (Head Nurse)*

*It is normal that young people have an accident from drinking because they like to ride motorcycles after drinking. (Buddhist monk)*

In this section, the stakeholders, with the exception of the student group, mentioned that the negative consequence of drinking alcohol was involvement in an accident. Interestingly, the student group did not want to talk about motorcycle accidents. The avoidance of the topic is likely to be significant but would require further exploration. However, accidents are identified as the most negative consequence of young people drinking alcohol and from the stakeholders' point of view were the most important thing to resolve.

### **7.5.2 Changes in individual behaviour**

The parents group commented forcefully on behavioural changes in young people who drank alcohol. Parent 2 agreed with Parent 7 who said:

*My son leaves home early but he does not arrive at school. I didn't know about this until the teacher told me about my son's behaviour. (Parent 7)*

She did not know her child's behavioural change until the teacher sent a letter to her. This was supported by teachers' views which showed that students who drank alcohol usually came to school late and fell asleep in classes. Parent 5 also commented on young people's sleeping patterns: "*after my son drinks alcohol, he will stay in his room*



*and sleep all day and not help me to do anything*". She indicated that her son is very lazy, and does not help with work in the house or the rice field.

Parent 8 described how children started to shout back and assault their parents. Parent 1 complained that she is suffering from her child's behaviour because he scolded her back and almost hit her when she told him off and admonished him to stop drinking. Moreover, the parent group agreed with Parent 2 who said:

*Children do not obey their parents but they will trust their friends. When we say 'Stop' they never stop. In contrast, when their friends say 'Stop' they stop immediately. (Parent 2)*

She claimed that young people change their behaviour by trusting their friends more than their parents. She tried to forbid her children from drinking alcohol and riding motorcycles at night but they do not obey her.

Similarly, the community leader described young people's change in behaviour after consuming alcohol. He said: "*young people are more aggressive and tend to fight with the other groups*". He commented further that children are still immature and have insufficient decision-making skills and sometimes cannot control themselves after drinking. Consequently, they usually make mistakes when they are in a gang. Another problem noted by the police officer is the link between behavioural changes and young people becoming a social problem or public nuisance. He said:

*Drunk children sometimes vandalise private and public property after they get drunk. They also damage public streetlights, traffic lights and telephone boxes.*

In this section, the parent group expressed their perspectives on young people's behavioural changes. In contrast, the student group did not want to share ideas about this. Perhaps it is because people who are close to young people will see the behavioural changes, whereas the young people themselves are not always aware of what they have done when they were drunk.

### 7.5.3 Fighting

Most participants said that fighting is a normal consequence of drinking alcohol and getting drunk. The police officer stated that it is common to receive a call to attend a fight:

*We receive a call every night about the young people fighting at the local food market, sometime in the pubs or bars. When we go there we find that young people are drunk.*

He claimed that the young people are more likely to drink at the local food market and in pubs or bars and then they will fight with other groups. It starts with somebody in group A teasing somebody in group B, which leads to an argument and finally to a fight. This is similar to the views of the community nurse, the Buddhist monk and Teacher 1. The latter added that the young people will fight readily if they meet a previous enemy. And particularly, if they meet their enemies who drink in the same shop and they are mindless. Student 5 and Parent 3 gave further information about the fighting which is divided into two types:

- Fighting with a member within the gang. Fights with another group member usually happen when the young people get drunk and have arguments.
- Fighting with someone in a different group. Fights with young people outside the group usually occur when they are drinking and encounter other gang members coming in to drink in the same shop.

In this section, the participants described how fighting seems to be normal for young people who get drunk. The fighting can be of two types: fights within a group and fights with members of other groups. If we look at the changes of individual behaviour, we find that fighting is a result of aggressive behaviour.

### 7.5.4 Poor school performance

Poor school performance is a big problem for young people who are studying. Teacher 1 indicated that the students are usually absent if they have got drunk, particularly if they drank on a weekday. He said: *“students are usually absent if they drank alcohol in the night before the school day. They report that they got sick or have a fever. After*

*that we know that they got drunk and can't go to school*". He clarified that the teachers will not know this until the students' friends inform them of the cause of absence.

Teacher 2 added that sometimes the students come to school but they usually sleep in class or do not pay attention. As the result of this, students will perform poorly, have uncompleted homework, failed examinations and low GPA. The Buddhist monk supported this view by saying: *"young people cannot study in classes if they drink because they fall asleep and pay no attention"*. Similarly, the student group agreed with Student 6 who said: *"we cannot go to school if we get drunk. If we can go, it will be late and we can't pay attention in the classes"*. They claimed that sometimes they do not understand the content of the subject in classes and cannot do homework and examinations.

In summary, the participants were concerned about the effects on school performance. The results of drinking alcohol and being unable to go to school will affect them through absenteeism, poor GPA, not giving attention to study, and failed examinations. Drinking on week day definitely affects the student's education more than drinking at weekends.

### **7.5.5 Health problems**

Health problems are an important negative consequence from drinking alcohol. Three parents indicated that they have observed a deterioration in their children's health and found that their children looked thinner and paler. For example, Parent 4 said: *"my son lost weight 2-5 KG this month, last month he is 60 KG"*. She explained that her son does not want to have dinner after drinking but needed to sleep. Moreover, all students agreed with Parents 7 and 8 who indicated that young people usually get drunk and then vomit. They seemed susceptible to fevers and usually had a cough.

Three participants had been concerned about unsafe sex. They stated that young people tend to have sexual intercourse after drinking alcohol. As the result of this, there are unwanted pregnancies and sexual transmitted diseases:

*Drinking alcohol will lead to have unsafe sex and get STDs. The big problem is it can lead to unwanted pregnancy. (Head nurse, community nurse)*

*I am worried about unsafe sex and sex in childhood. After young people drink, they tend to have sexual intercourse and do not use condoms. (Community leader)*

*It is a big problem that students drink and will have sex in childhood while they are studying. (Teacher 1)*

Teacher 2 explained that the teachers at the school will not know about the students' health problems because they have stayed at the school only for a short time. He stated that the long term effects will show after the students have been drinking for 3-5 years by which time they would have left school and gone to university or into employment. The healthcare providers were concerned about alcoholism. Similarly, the policeman pointed out that drinking alcohol can affect the internal organs. They said:

*Young people tend to have alcoholism if they drink a lot and drink for long time. We have to give them an education to refrain from drinking. (Head nurse)*

*We don't know when young people will stop drinking, they can get alcoholism. (Director of the nursing school)*

*For long term, alcohol will affect the internal organs. Young people will get cirrhosis, hypertension or peptic ulcer. (Policeman)*

In this aspect, the participants had noted the short term and long term effects on health. In the short term there would be weight loss, drunk, getting a fever, vomiting, and unsafe sex. The long term problems included alcoholism, and more diseases. Furthermore, some health problems could lead to other problem, for example, unsafe sex could lead to unwanted pregnancies.

### **7.5.6 Reflection summary**

The consequences of drinking alcohol are so important that the participants have to encourage young people to be concerned. Some consequences can be linked to the others, for example, behavioural changes can be the cause of fighting, poor school performance, and accidents. For the health problems, there are both short term and

long term effects. Young people have to be informed of the effects of alcohol in order to obtain more knowledge and for them to consider whether alcohol is good or bad. It should be good if the young people have sufficient knowledge to encourage themselves from drinking alcohol.

## **7.6 Prevention strategies**

Drinking alcohol is socially accepted as a pleasurable activity. However, drinking among youths is widely recognized as one of the leading public health problems and policy concern in countries around the world (Young *et al.* 2006). A prevention strategy is the best way to help young people to refrain from alcohol. In this study, I have interviewed the stakeholders in Community C to gain suggestions for appropriate strategies to prevent young people from consuming alcohol which are described below.

### **7.6.1 Prevention strategy by the family**

The participants stated that the family is the best source of teaching young people to avoid drinking in three aspects; 1) nurturing care and protection, 2) giving encouragement and teaching at home, and 3) setting a good example at home.

#### **7.6.1.1 Nurturing care and protection of children at home by the family members**

The community leader indicated that the family is the most important source to protect children from drinking alcohol and a warm family can protect young people from drinking alcohol. He said:

*The environment is very important to protect them from drinking alcohol and from any vices. They have to receive warmth from their families. I would like to say that parents are very important people to take care their children. They have to teach their children about the negative effects of alcohol and they have to practise good activities as an example for them. (Community leader)*

At the same time, the director of nursing school stated that strong family relationships could help parents to prevent their children from drinking alcohol. The community nurse agreed with this view that parents have to play a very important role in taking care of their children by teaching responsible and acceptable behaviour. Furthermore, the community leader and the community nurse compared the warmth from family members to a vaccination that protected young people from consuming alcohol. Moreover, they added that children who had warm family bonds would obey their parents and be less likely to misbehave.

### **7.6.1.2 Teaching at home**

Teaching at home is a very important activity that encourages young people to know about the consequences of drinking alcohol. Parents can be very influential role models. The student group agreed with student 5 who said:

*We should be taught about the alcohol's effects and not to drink it at home when we are boys. It is very difficult to understand this when we are adolescent because we will spend a lot of time with friends.*  
(Student 5)

They claimed that parents are close to their children. Therefore, parents should be the first people either responsibility to teach their children at home. Students said that they should be taught about the negative alcohol consequences while they were still in childhood (aged 7-12 years old). They would not obey their parents when they are adolescent because they would bow to pressure from their friends and follow their friends instead. In this case, Parents 3 and 5 added that teaching young people while they are still in childhood is good because they will gain more knowledge and behave better as they grow up.

The head nurse and director of the nursing school expressed the same idea as the community nurse who said: *"we should train our children not to drink alcohol when they are children. Family members are responsible for this. We have to teach our children what a sin is and what a virtue is"*. They stated that encouraging children is the responsibility of all family members and must be done early on. It would be too late if the family members did not teach and train their younger family members at

home during childhood. It was quite difficult to teach young people when they were growing up.

In addition, the Buddhist monk indicated that teaching at home is the best strategy to prevent young people from drinking alcohol, particularly teaching through setting a good example by the father and mother. This supported the teachers' perspectives, who said that: *"teaching at home is more effective than teaching at school. Parents have a lot of time to teach their children, in contrast, teachers have limited time to teach them. It is only in classroom"*. Teacher 1 added that teaching in the family is a very easy and effective way, children can understand and take on board what their parents tell them. He also compared things with his generation:

*For my generation we have a proverb which says 'Adults have taken a bath with warm water before you'. This means adults have many experiences, much more than children and they can teach children how to manage their daily lives. We have to obey our parents, when they said 'Stop' we had to stop. In contrast, the new generations do not obey their parents. (Teacher 1)*

In his view, the experiences from family members will teach young people to gain knowledge to protect them from behaving badly.

#### **7.6.1.3 Parents as a good example**

Setting a good example is an effective way of preventing young people from drinking alcohol. Most participants stated that fathers and mothers are the important model that children will copy. Parents who show respect, kindness, and honesty to their children will encourage them to behave in the same way.

The police officer explained that children want to copy their parents' behaviour:

*Parents and family members should set a good example to children by not consuming alcohol in front of them. Children often copy the behaviour of key adults in their lives. For example, parents sometimes take children to parties and drink alcohol; afterwards, children will follow their example.*

In his view parents and family members had to be seen to behave in an acceptable manner as an example for their children. The community leader's opinion was similar:

*If we want to encourage students not to drink alcohol, we have to work with them from childhood. Furthermore, parents have to have good manners. They should not drink or smoke in front of children. I saw a family near my house and the father smoked in front of his baby then his baby picked up the cigarette and put in his mouth. At that time the grandmother saw this, she slapped the baby's mouth and said 'Smoking is bad, you don't do that.' This is one example of training. (Community leader)*

These comments show that children are believed to copy readily the behaviour of their parents and other family members. Student 2 supported this: he was taught by his mother that drinking alcohol is bad but he does not know why his father drank. He also indicated that he start drinking by copying his father's behaviour. Student 6 agreed with him by complaining: *"my parents are the most influential persons in my family. In my opinion, everything that my parents do is good and I want to follow. I don't know that it is right or wrong. I only copy the activities that I see from them"*. He commented that from a child's perspective all activities that he saw his parents do are good and he needed to follow. Therefore, fathers and mothers have to teach and train good manners as an example for their children. The student added that children do not have sufficient critical thinking to consider what is good or bad behaviour.

Similarly, Parent 5 described how she teaches her son not to drink alcohol by giving an example of her husband's drinking. She said: *"I told my son to see his father as an example, his father drinks alcohol a lot and he got cirrhosis, hepatitis, and looked very thin"*. This is the same situation as Parent 8 whose husband had died from excessive drinking.

The Buddhist monk agreed with the community nurse who stated that:

*Parents need to set a good example with their behaviour for children. Children will copy what they see. A family member has the first and a school teacher the second responsibility for training children.*



She claimed that parents have to teach children with responsible and appropriate behaviour and that words alone are not sufficient.

In this section, participants were clear that parents and family members can help each other to prevent young people refraining from drinking alcohol. The activities within the family should include taking good care, teaching, being responsible, showing kindness, demonstrating honesty and setting examples of acceptable behaviour. However, all activities to encourage young people should be initiated while they are in childhood because at this stage, they want to copy all parental behaviour that they see. It is difficult if parents teach the young people in adolescence because they spend a lot of time with their friends and they will obey their friends more than their parents.

### **7.6.2 Prevention strategy by the schools**

The teachers are the key people in school to encourage students. After young people are taught at home, the school is the next place where teachers can teach them to avoid alcohol. In this section, I will identify the participants' perspectives of the activities at the school for persuading students to refrain from drinking alcohol.

#### **7.6.2.1 Modifying the curriculum and teaching at schools**

Students and teachers indicated that one cause of young people drinking alcohol is that insufficient time is set aside for teaching about it and it is too late to teach them in secondary school. Student 2 suggested that the school principal and teachers should modify the primary school curriculum by adding sufficient time for teaching about alcohol consumption and its consequences.

The police, healthcare providers and the Buddhist monk agreed with the community leader who commented that school teachers should have to include alcohol consumption as a topic in the curriculum. He believed that if the students knew about the consequences of consuming alcohol, then they would not drink. It is a responsibility of school teachers to encourage students to avoid drinking alcohol, as parents teach at home.

Parent 1 expressed her thoughts about teaching at the school and young people drinking:

*I think teachers should help by teaching them at the school. The students will obey teachers more than their parents because the teachers can give them a mark or punish them when they make a mistake.*

In her view students will obey teachers because they will be punished if they make a mistake and that is a good way to encourage students to be aware of the dangers of drinking alcohol. Another concern is how to teach morality in school. The community leader agreed with Teacher 1 who claimed that there used to be the subject of Morality in the past. However, this subject disappeared from the curriculum. The subject of morality would cover what is sin and what is virtue, and what is the responsibility of good people. He said that if this subject were reintroduced, it could encourage students not to access alcohol:

*In the past, there is a subject of morality which teaches children to be a good guy, and talk about what is sin and what is virtue. I don't know why it disappeared because it is a good way to encourage students. (Community leader)*

*There was a subject of morality in our school curriculum but it was cancelled many years ago. This subject is good to encourage students to be good students. I think we should issue this subject to the school principal. (Teacher 1)*

In summary, this is an important aspect where participants described modifying the curriculum and teaching at school as good ways to protect students from consuming alcohol. The school principal should think about how to modify the curriculum by giving more time for the topic of alcohol consumption and its consequences also of morality. Another point made is that it is better if education about alcohol is taught in the primary school where the young students will gain more knowledge to protect themselves from drinking alcohol.

### 7.6.2.2 Teachers are a good example

Teachers are good models from whom students can copy their behaviour. The Buddhist monk described how teachers' behaviour sets an example for students to follow:

*Sometimes teachers teach the students to avoid alcohol but they drink in the evening when they finish their jobs. They should set a good example for their children to copy, for example they shouldn't drink alcohol in the evening after work, and not drink at the school. (Buddhist monk)*

From this excerpt, the monk claims that the teachers' drinking behaviour after work could set an example for students to copy. He suggested that teachers should be of good behaviour as an example for their students. Teacher 1 also insisted that teachers should be a role model by playing sports and not drinking alcohol:

*I think teachers in our school have to practise good behaviour as an example for our students. When they see our behaviour, they will copy. I think playing sports when we have free time in the evening is a good idea. Absolutely, we should not drink alcohol. (Teacher 1)*

Setting an example is important for teachers who teach students in school. They are the good models like fathers and mothers at home. Therefore, teachers must be of good behaviour as an example for their students to follow.

### 7.6.2.3 Cutting marks and keeping a 'Drunk List Record'

Cutting marks and keeping a Drunk List Record are two strategies for controlling students who access alcohol, particularly those drinking in the school. Teacher 1 said:

*I have a record of drunk students. The students' names will be recorded in the Drunk List Record if I meet them drinking alcohol and then I will send this record to their parents to let them know. Students are quite scared with this strategy. (Teacher 1)*

He indicated that this record is a good strategy to control drinking alcohol in school. He records student's names in his 'Drunk List Record' and will send this document to drunk students' parents to let them know as a warning to the students.

Another strategy was identified by Teacher 2 who said that the students would have their marks reduced by 15 marks for every time the teachers saw them drinking alcohol in school. This would affect their studying and examinations. As a result of this, the teachers described how the number of students who drink at the school is decreasing.

Through examining these participants' opinions, we can see that modifying the curriculum to improve its content and to encourage more knowledge at school about alcohol is very important strategy. The participants believe that if students learn more about alcohol consumption then they will not drink it. At the same time, teachers should be good role models for students, and therefore, teachers must be of good behaviour as an example for young people. Finally, cutting student's marks and the Drunk List Record are other useful strategies which participants have recommended because they show that the number of students who drink alcohol in school is decreasing.

### **7.6.3 Prevention strategy by the community**

Community members can play an important role in helping to control the alcohol consumption of young people in the community. The community, as a whole, sees it as its responsibility to prevent children getting access to alcohol and ensuring that young people who do drink alcohol do so responsibly. The participants expressed their opinions about how the community members prevent the young people from consuming alcohol using various strategies.

#### **7.6.3.1 Taking care and teaching children in the community**

Parents cannot always be sure that their children behave responsibly when they are out of the house. People in the community can help parents by informing them if they see their child drinking alcohol or misbehaving in the community. The community nurse explained that young people in Community C are likely to gather or meet at hair dressing salons or a motorcycle garage when they have free time. She said:

*Adolescents usually meet at salons and the motorcycle garage, and then drink alcohol almost every evening. We should talk to the*

*owners about helping us to teach young people who should stay away from the alcohol.*

She recommended that salon or garage owners could observe young people's behaviour and if necessary feedback information to their parents, particularly when the young people drink alcohol.

Moreover, the director of the nursing school indicated that the community leaders have to be concerned about this problem. They should formulate a community policy and enforce it by encouraging all adults in the community to teach the young people to refrain from drinking alcohol. Similarly, the community nurse claimed that the community leaders should survey young people in the community in order to find youths who drink, and then give feedback to their families for further information to find the appropriate strategies to prevent them from alcohol.

#### **7.6.3.2 Adults are a good example**

Student 2 agreed with Student 4 who complained that one factor that leads him to drink alcohol is seeing adults drinking in the community and the same adults offering him alcohol:

*I see adults in our community drinking alcohol at a party, and then I drink. They should set a good example for us. In particular, they should not offer us alcohol when we go to a community party.*  
(Student 4)

Student 4 suggested that adults should set an example of good behaviour and responsible drinking for young people to follow. In support this, the director of nursing school said that they have not to drink and nor persuade young people to drink with them.

#### **7.6.3.3 Conducting a youth club and providing part time jobs**

It is very important to think about the youth club and part time jobs for young people. This is the director of nursing school's view:

*The community leaders should run the youth club for children e.g. To Be Number One or providing a part time job in the community. The young people will tell their friends to join the youth club activity and they won't want alcohol because they have many friends there and have an activity to do. They do not have time to think about the alcohol.*

She asserted that the community leaders should organize suitable activities for the young people by running youth clubs or providing part time jobs in the community. She explained that young people would spend their spare time on youth club activities with their friends, or in part time jobs. A result of these activities might be that they would not have spare time even to think about drinking alcohol.

#### **7.6.3.4 Constructing sufficient sport fields**

Members of the student group complained about the sports fields. Student 7 said that young people start drinking alcohol because there are not enough sports fields for playing sports:

*The community leaders should construct lots of sport fields. We could then play sports instead of drinking alcohol. Normally, adolescents meet and drink alcohol almost every evening because there is no activity to do in their spare time. (Student 7)*

He commented that young people have a lot of spare time and can get bored. They might be easily persuaded to access alcohol by the youths who have left school early or adults in the community. Student 1 supported this idea by indicating that children would spend their spare time after they come back from school by playing sports with their friends. This might lead them to avoid alcohol, keep them fit and strong, and promote good health.

To summarize, people in the community are one of many key people to help. A prevention strategy by the community is an important aspect of preventing young people from drinking alcohol when they leave their home or school and spend their spare time in the community with their friends. If the community leaders and community members are concerned enough to provide the activities described above, they can protect children in the community to effectively refrain from alcohol.

## **7.6.4 Prevention strategy through policy**

Policy is an effective strategy for controlling alcohol consumption by young people, and the Alcohol Act has been formulated to control alcohol consumption. In this section, I will clarify the views of the stakeholders towards the alcohol policy about controlling alcohol consumption by young people.

### **7.6.4.1 Restricting policy enforcement**

The policy makers have formulated the Alcohol Act and enforce it but Student 6 claimed that government officers have not strictly enforced it. He said: *“I think the alcohol policy must be seriously enforced, it will control the alcohol consumption effectively”*. At the same time, Parent 1 talked about police action on the policy:

*I think if the police seriously take action by enforcing the policy in this community, the young people will be scared and unable to get alcohol from the community shop. The shopkeepers should be punished if they sell alcohol to young people. In contrast, the police only say, there is no punishment. (Parent 1)*

She commented that there is no restriction on alcohol sales in the community and the shopkeepers who sell alcohol to young people are not punished. The police only verbally warn the shopkeepers with no charges or punishment. Understandably though, the shopkeepers are not concerned about this. Similar was the Buddhist monk's view, who complained that the Alcohol Act is very important for Thai society. If people do not break the law, it can control alcohol consumption in the community. However, the government officers do not seriously enforce the policy, so it cannot be an effective control.

### **7.6.4.2 Continuously setting an anti-alcohol campaign**

Continuous anti-alcohol campaigns are necessary. The director of the nursing school claimed that the Alcohol Act is only enforced at special festivals. She said: *“the Alcohol Policy is only seriously enforced on special occasions, for example, the Songkran festival or the New Year festival”*. She commented that if it were always enforced, it would control alcohol consumption effectively. This view was supported

by the head nurse who stated that the anti-alcohol campaign is not clearly shown on packaging. She compared it to the anti-smoking campaign which is more effective because the cigarette companies place a distressing picture on the package that make young people scared. She suggested that a similar alcohol warning campaign should be done with alcohol packaging. Another marketing strategy used nowadays by alcohol companies is sponsorship of major sports competitions. The policy makers should be concerned about this and decide whether to allow alcohol companies as the main sponsors.

#### **7.6.4.3 Noticing of the punishment of people who breaking the Alcohol Act**

Student 1 complained that he did not know about the details of Alcohol Act. He said:

*I don't know what the detail of the Alcohol Act is. I think people who are responsible to enforce the policy should present this in school, TV or comic book. (Student 1)*

From the excerpt, he advised that the policy makers should organize an appropriate strategy to encourage young people to understand the details of Alcohol Act by promoting it in school, television programs, or cartoon.

In summary, policy is thought to be an effective strategy for controlling alcohol consumption. The policy makers are the key people to formulate the policies and the police are important people for enforcing them. The stakeholders described this strategy as policy enforcement, continuous anti-alcohol campaigns, and public awareness that people who break the law will be punished. However, it is very important to encourage young people to understand the details of the law.

#### **7.6.5 Prevention strategy by the healthcare team**

A prevention strategy by the healthcare team is another strategy for helping to control alcohol consumption. In this section, I shall present two suggested aspects of such a strategy.



### 7.6.5.1 Conducting health promotion in schools

Students 3 and 6 agreed with Teacher 1 who suggested that the healthcare team should organise an alcohol camp or training programme in school to promote young people's health. Student 3 said:

*The staffs from the hospital should organise the alcohol camp at our school to promote us our knowledge about the alcohol, for example, alcohol effects, how to avoid from alcohol, and the Alcohol Act.*

Student 6 indicated that the nurses should set up a training programme or workshop to encourage students to be aware about alcohol. Moreover, Teacher 1 recommended that it would be a good project if the healthcare team set up a programme for students in school focussing on alcohol and the negative effects.

### 7.6.5.2 Health teaching in hospitals

The Healthcare Providers described how it is a great opportunity to give health education when the young people get drunk and come to the hospital's emergency department:

*We can give the young people an individual health education when they come to hospital after they have had an accident or health problems. (Head nurse)*

*We take care of the young people's problem, and after that we have to give them knowledge about health promotion and how to prevent from drinking alcohol. (Community nurse)*

The healthcare team could encourage the young people to think about the negative effects of drinking alcohol when they are admitted to the hospital. The healthcare team should teach not only young people but also their friends and family members who take them to the hospital, to be aware about alcohol.

In this category, it is suggested that the healthcare team can promote young people's health by conducting a variety of programmes of alcohol control in school or in hospital. This can support young people in avoiding drinking alcohol and will give them a better health status.

### 7.6.6 Prevention strategy by restricting alcohol sales

The restriction of alcohol sales is necessary for shop owners in the community. The policeman said that shop owners should be aware that they are selling to underage people:

*I think the shop owners should be encouraged about the responsibility of selling alcohol to young people. They have to be concerned more about the negative effects from drinking alcohol than earning money. Another thing they have to think about is that this can lead to social problems and economic problems.*

He explained that shop owners must be responsible when selling alcohol because it can lead young people to access alcohol, with negative consequences. To support this, the community leader complained: *“the police have to punish the shopkeepers who sell alcohol to underage”*. He clarified that selling alcohol to children is illegal and that the police should punish the shopkeepers. Furthermore, two students and the Buddhist monk mentioned that the shopkeepers should not sell alcohol to children when they come to the community shops. They also recommended that the owners should strictly adhere to the alcohol sale policy.

Moreover, Parent 2 agreed with the community nurse who commented that the community shops should be controlled by a licence and the police should have to inspect them frequently. If the shop owners did not have a licence, then they could not sell alcohol, thus controlling alcohol consumption by young people. This can be described in the following comments:

*The government officers have to inspect the licences for selling alcohol in community shops. This can control the number of community shops in Community C and the shop owners will be scared to sell alcohol to young people. (Community nurse)*

The findings above showed that young people could access alcohol easily by buying it from the community shops. Therefore, the shop owners must be aware of their responsibility not to sell alcohol to children which is illegal and get punished for it. If the shopkeepers are aware about the alcohol sale, it could help to prevent young people from drinking alcohol.

### **7.6.7 Prevention strategy by increasing young people's self-awareness**

In this section, I will share the participants' views on a prevention strategy involving the increase of young people's self-awareness about their decision-making and negotiation skills. The main point is to encourage young people to reinforce their awareness by themselves.

#### **7.6.7.1 Decision-making and negotiation skills**

The head nurse agreed with community nurse who asserted that young people have to gain more knowledge and learn how to refuse alcohol from their friends. In this age group, young people always obeyed their friends more than their parents and they wanted to conform to their friends' behaviour. She said: *"decision making is very important for young people to decide that drinking alcohol is bad for their health. If they know something is bad for their health, they will not access it"*. She explained that if young people obtain more knowledge, then they would have the critical thinking to make the decision that they should not drink.

The community nurse also explained that negotiation skills are important skills which children can use to refuse alcohol:

*I think negotiation skill is very important skill for young people to refuse alcohol from their friends, they will encourage their friends to do exercise or drink juice instead of drinking alcohol.  
(Community nurse)*

She explained that young people could negotiate to do something other than drinking alcohol such as exercising or drinking juice. Students 4 and 5 supported this view, they expressed that young people should have to persuade themselves to behave well such as by playing sports instead of drinking alcohol.

In summary, self-awareness is an effective strategy that young people should develop particularly decision-making negotiation skills. Decision-making is the process resulting in the selection of a course of action among several alternative scenarios and it produces a final choice. Negotiation is a process by which people settle differences,

and compromise or agreement is reached while avoiding argument. The methods can be used to prevent young people from alcohol consumption. In this case, young people have to be taught how to develop these skills, and then they will understand and use them to refuse alcohol from people who offer it to them.

### **7.6.8 Prevention strategy using restriction of alcohol advertising**

Teacher 1 commented that nowadays, young people spend a lot of time on surfing the Internet which is full of advertising. He described how it is very easy to see the advertisements on various media and added:

*Today students spend a lot of time on the Internet. They feel very confident about doing everything by searching on the Internet. Also, students are addicted to gaming and are reached through online media by advertisements about alcohol consumption and they want to try what they see. Therefore, the government officers have to restrict the alcohol advertising. (Teacher 1)*

In this excerpt, the teacher commented that policy makers need to be concerned about this and should restrict advertising content and the time of broadcasting. In the same time, young people should manage time table to study and surf the Internet where have a lot of advertising. This was agreed by the community leader who recommended that the restriction of alcohol advertising is very important and helpful in preventing young people from drinking alcohol.

Student 7 supported the view that alcohol advertisement should not be allowed on TV or the Internet. He suggested that government officers should block alcohol advertising. However, Student 1 claimed that advertising should be used to spread information about the Alcohol Act and about how to refrain from drinking alcohol.

A prevention strategy restricting alcohol advertising on the Internet and other media is seen as an effective strategy for controlling alcohol consumption by young people. As a result of having no restriction, young people can access alcohol which they see in the advertisements. The government officers should seriously recognize and restrict the content and timing of advertisement broadcasts.

### **7.6.9 Reflection summary**

In summary, this subtheme showed that the stakeholders have recognized about how to prevent children from drinking alcohol. From the findings, the participants indicated that prevention strategies should be realized by families, schools, communities, policies, healthcare teams, restriction of alcohol sales, self-awareness, and restriction of alcohol advertising. All appropriate strategies will be effective if all stakeholders in the community have to help each other. The actions to prevent young from drinking alcohol should be integrated from family to school, from school to temple, and from temple to community. Actually, everyone has to help by selecting the appropriate strategies to use with the young people, for example, parents have to teach their children at home, and teachers have to teach students in school.

## **7.7 How to succeed with the alcohol prevention strategies**

After perceiving prevention strategies, the stakeholders have to think how to successfully enforce the strategies towards young people to control alcohol consumption. Generally, all stakeholders in the community have to be active in alcohol prevention in the area that they can influence. Only then would it be successful and bring benefits to the community. In this case, the participants have defined the method to succeed with alcohol prevention strategies in three ways.

### **7.7.1 The community network**

The policeman admitted that it is perceived by people in the community that everyone expects the police to take action to control young people's alcohol consumption. Indeed the police can take action, but to be successful the police personnel and also all people in the community, particularly teachers and parents, have to be proactive. The community leader and two parents agreed with Student 3 who said that everyone in this community has to help the police to control this problem. He said:

*I think everyone in the community has to help to resolve the problem, nobody can deny because it is the community members' responsibility. (Student 3)*

Parent 6 gave the example of parents taking action at home and teachers at school. Subsequently, the community leaders should take action in the community. The police had to enforce the law, and the healthcare providers should help by checking the health of young people who are addicted to alcohol, and supporting treatment for them.

Parent 3 advised that the Buddhist monk is an important person because he is a spiritual guide of living. She said: *“I think Buddhist monk can help me by giving a Dharma talk at the temple about the Five Precepts and drinking alcohol is a sin”*. She indicated that the monks should encourage young people to refrain from drinking alcohol by teaching about this issue whenever there are Buddhist activities at the temple. The Buddhist monk supported the concept that family, school and temple are the most important sources of encouragement to young people not to drink alcohol, with which parents, teachers and monks must cooperate seriously.

Similarly, the head nurse agreed with the director of nursing school who said:

*There should be a networking centre for the community to cooperate and coordinate activities that everyone comes to join and share ideas.*

These ideas suggested that people in Community C should form a network which would include all stakeholders in order to resolve the problem of young people. The centre of the networking will be a place where everyone can inform each other of the problems they are experiencing in their area. She explained that a meeting and discussion with community team members can be held.

Moreover, Teacher 2 explained that everyone in the community is important. He said:

*Everyone has to help. If parents teach the children but teachers are not interested, it will be unsuccessful. Similarly, teachers teach students but they see people in the community drinking alcohol or buy from a shop so they can access alcohol. (Teacher 2)*

His words suggest that cooperation between family, school and community is successful if everyone is concerned about the problem; for example, if parents teach young people that drinking alcohol is bad but the teachers do not reinforce that message at school, then it may not succeed. This is the same as if students are taught

at school but the teaching is undermined when unconcerned shop owners still allow young children to gain access to alcohol.

In this category, a network is very important and necessary for community members to resolve the drinking problem. All stakeholders in the community have to help each other to inspect and remove illegal activity. The action is interrelated between family, school and community and is defined as everyone's responsibility.

### **7.7.2 Police responsibilities**

The police are key people for enforcing alcohol policies and controlling alcohol consumption by young people in Community C. The police officer said: *"to enforce the Alcohol Act is our responsibility and the community members expect us to take action seriously"*. He added that he cannot deny that this responsibility is theirs alone. Indeed police are the main organisation to take action and they would persuade all community members to join the activity.

Furthermore, two parents agreed with the head nurse who commented that the police should rigorously enforce the Alcohol Act, not just on special occasions but as part of their regular duties. She stated that the police should inspect the community shops and encourage the shop owners to be concerned about the negative effect on young people, and remind them that it is illegal to sell alcohol to underage customers.

In this section it is clear that the police are seen as the key people who have a responsibility to enforce the law in the community and that the other stakeholders are the partners. The police were recommended to take action seriously and consistently in order to control the alcohol consumption by young people in Community C.

### **7.7.3 Punishment**

In this section, the police and the teachers comment on the effect of punishment on young people who drink alcohol. However, the students and the community leader point to the shop owners.

The police indicated that young people who get drunk and cannot control themselves will be taken to the police station, and their personal details will be recorded:

*We will take young people who get drunk to the police station and record them in a Drunk List. Then we will call their parents or teachers to accept their indictment and take them home or to school. We usually teach them about the law and alcohol effects before getting them home and we encourage their parents or teachers to teach them more advice. (Policeman)*

He described how the police will teach young people about the Alcohol Act and the negative consequences of alcohol after taking them to the police station. After that the parents or teachers are allowed to take young people home or to school for further suggestions. He added that in cases of fighting, the police will call young people's parents to accept the indictment and pay for damages. This led to a significant decrease in the number of young people taken to the police station.

Moreover, Teacher 1 explained that students who drink alcohol in school will be recorded in the Drunk List Record. Their parents will receive a letter to let them know about the students' problem and let the parents teach young people about unpleasant behaviour. Furthermore, Teacher 2 supported the strategy of students' marks being cut down by 15 marks if they drink alcohol in school. If they are cut down by the full 100 marks, then they will not be allowed to sit the examination. The teachers said that after using this strategy, the number of students who drink in school decreased.

On the other hand, the community leader agreed with the students who commented about the shop owners being punished:

*The police should punish the shop owners because they sell alcohol to us and they know it is illegal. (Student 7)*

The shop owners do not care about the consequences, they only think about making money. Therefore, the shop owners should be punished and encouraged to respect the law.

In summary, punishment is one strategy for controlling alcohol consumption by young people. They will be scared about being recorded in the Drunk List and their parents



getting to know about their behaviour. Cutting students' marks is also an effective strategy. The statistics from the police and teachers showed that the numbers of young people who drink alcohol is definitely decreasing. Another thing that is considered important is punishment for the shop owners who sell alcohol to children because they are breaking the law and assisting young people in gaining access alcohol.

#### **7.7.4 Reflection summary**

The alcohol prevention strategies are important but how to make them work is more important. Networking, police responsibility and punishment are suggested as ways to make the work effectively. This means that all stakeholders in the community have to assist each other. The police are the key organisation to take action through strictly seriously enforcing the law and community members will support them. However, punishment is also an effective way of reminding young people and shop owners not to break the law and school regulations. This can prevent young people from drinking alcohol.

### **7.8 Buddhist practice**

Buddhist practice is a prevention strategy that all participants suggested was the best way to prevent young people from drinking alcohol because they live in a Buddhist society. In the following section, participants share their perspectives in various ways.

#### **7.8.1 Buddhist practice in the Buddhism**

The community leader stated that Buddhism was the way that people in Community C should practise:

*Thailand is a Buddhist community and Buddhist practice is part of Buddhist way. Parents should take their children to the temple for Tamboon<sup>33</sup>, chanting and learning about Buddhism. People who are Buddhist will be taught about sin and virtue.*

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<sup>33</sup> Tamboon means "the activities that the Buddhists do such as donation, gaining merit by going to the temple to worship Buddha, or offering food to Buddhist monks (Saibatr)" (Chamratrithirong *et al.*, 2010)

For the community leader, Thailand is a Buddhist country where people commit to the Buddha's teaching. He also encouraged parents to take their children to the Buddhist temple in order to get to know the Buddhist practice. Children would then know what a sin is and what a virtue is. The police officer agreed that the Buddhist way could be used to prevent young people from drinking. He said: *"I think Buddhist way is useful. We are Buddhist and it can help us to prevent young people from drinking alcohol. We believe in Buddha's teaching."* He explained that if children were practising Buddhism, they would believe in Buddha's teaching about refraining from alcohol. Similarly, the students also said the Buddhist ways of practice<sup>34</sup> can help them to refrain from alcohol, and then they will think about making merit. Students 1 and 3 agreed with the view of Student 7:

*We believe that the Buddhist way is the best way because Buddha teaches me to make good deed more than to do a sin and then Buddha teaches me to refrain from alcohol because it is a sin.*  
(Student 7)

Parent 5 commented that some children did not believe in the Buddhist way. She said: *"Some children don't believe in the Buddhist way. If they believe it, I think they won't drink alcohol because they will know that drinking is a sin in Buddhism."* She stated that if there was a strategy to persuade children to follow Buddhist practice, it could help them to consider, in Buddhism, that drinking is a sin against Buddhism and so they would be less likely to drink. This was supported by Parent 6 who gave an example of the parent of one family she saw who lived near her house:

*I see a couple who live near my house. They have a child and they take their child to the Buddhist temple while he is in childhood until he is 18 years old. Their child is very good boy, he never does bad thing and never drink alcohol.*

This child became exemplary and would never do a bad thing and particularly he would never drink alcohol. This view was confirmed by the Healthcare providers. The

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<sup>34</sup> The Buddhist way is "a series of practices and a way of life based on the teachings of the Buddha who, after achieving enlightenment, taught that the nature of the world is constant change, and a way to correct our view, conduct and expectations of life in order that we can bring an end to suffering and share in the happiness, wisdom, peace and Nirvana that Buddha himself discovered after following the paths of the lessons he has since laid down as the foundations of Buddhism" (Buddhist studies, 2013).

community nurse compared the positive influence of Buddhism on children's behaviour with that of the Muslim children who are taught about religious regulations from childhood so that they are taught that drinking alcohol is a sin and therefore they will never drink:

*Have you ever heard about the Muslims? The Muslim people will teach their children from childhood about the religion and their children won't break the religion's regulation. They know alcohol is a sin and they won't drink it.*

The head nurse added that the Buddhist precept was very useful if people in the community taught the young people about it. The director of the nursing school also supported how the children should understand the Buddhist way and apply it in their daily live. Similarly, the Buddhist monk said: *"the Buddhist way is very useful if young people know about the themes of Buddhism which they can apply in their lives."* Teacher 2 agreed with this view: *"The Buddhist way is easy to practise. If people practise and apply it in their daily lives, they will be happy."*

Both teachers agreed with all the other participants' perspectives. Teacher 1 indicated that Buddhism is good and very useful if young people practise following the Buddha's teaching particularly the Five Precepts:

*I think Buddhism is a good concept and very useful for young people. If they practise following the Buddhist way particularly the Five Precepts, they will avoid alcohol. Every Buddhist is taught to know about drinking alcohol being a sin. People who seriously practise will not access alcohol and they can tell the others. In contrast, people who do not practise will not believe and drink it and think this is a normal habit and no one can punish them.*

These opinions express the view that every Buddhist is taught that drinking alcohol is a sin and therefore, people who seriously practise Buddhism would not access alcohol. In this case, the Buddhist could tell young people to follow the Five Precepts seriously. In contrast, young people who did not seriously practise Buddhism would drink alcohol and think it a normal habit rather than something for which they should be punished.

It is clear from these comments that the participants in this study believe that the Buddhist way is an effective strategy to prevent young people from drinking alcohol. The Buddhist way can be applied by young people to assist them to abstain. Young people who seriously practise following the Buddhism precept will understand that breaking the precept is a sin. Refraining from drinking alcohol is one of the Buddhist precepts that young people should follow and apply in their daily lives.

## **7.8.2 Buddhist practice in the family**

The family is a very important source of teaching and training. Parents and family members are the key people with these functions. The Buddhist practice is one way that family members can use to teach and train young people in order to prevent them from consuming alcoholic beverages. This next section will explain the importance of the Buddhist practice within the family with the subthemes of teaching and practice at home, and family members as role models.

### **7.8.2.1 Teaching and practice at home**

Teaching and training at home is very important, particularly about Buddhist practice. The police officer explained:

*The family is the important starting place to teach the children. Parents have to teach and practise good behaviour for their children such as the five precepts of the Buddhist practice.*

He claimed that parents had to recognise that the Buddhist practice was the good practice that should be fostered in young people. The community nurse and teachers added that parents and family members are the key people to encourage the belief in young people that they should abstain from alcohol:

*The Buddhist practice; The Five Precepts is like a vaccination for disease protection. If we teach the precepts to our children they will have more knowledge to consider what they ought to do. A family member has the first responsibility to train children then the school teacher. It is like teaching children to wash their hands before eating, when they grow up they will continue to do that. (Community nurse)*

The community nurse said the Five Precepts of Buddhist practice expect family members to have the primary responsibility to train children, and then their school teachers. She compared the Buddhist practice to a ‘vaccination’ which would protect children from bad behaviour. The practice should be fostered in children while they were young and then would continue with it. This was supported by Teacher 2 who agreed with Teacher 1 who said:

*Father, mother and family members are important people to teach and train children practise the Buddhist practice. They would not do bad things and will be a good guy when they are going up.*

The findings showed that parents should teach their children about Buddhist practice and then they should practise by example. If the family members teach and persuade young people to follow Buddhist practice, they will be less likely to behave badly and more likely to grow up as responsible members of the community.

#### **7.8.2.2 Family members as role models**

The policeman stated that parents must be a good role model for their children in behaving appropriately and displaying good manners. Moreover, Teacher 1 indicated that children would copy the behaviour of their father and mother. Therefore, parents and family members had to behave well. Drinking alcohol is one example where the parents have to teach their children to understand what they should or should not do. Thus, parents and family members should be aware of why they need to do this as the following quotation demonstrate:

*Children will copy their parents and family members. Therefore, parents and family members must teach them that drinking alcohol is bad behaviour and not to drink. However, parents must provide a good example. (Teacher 1)*

The subtheme of Buddhist practice in the family showed that parents and family members should act as examples for young people to follow. Teaching and practice in the family, and family members as role models are the strategies that participants recommended. The important point of these subthemes is that family members particularly father and mother are viewed as the key people to take on this activity.

### 7.8.3 Buddhist practice in school

Buddhist practice in school is as important for the students as Buddhist Practice at home. Some participants expressed their ideas about this in the following perspectives.

#### 7.8.3.1 Teaching at the school

Parent 6's words describe how Buddhist practice was good for alcohol prevention and very easy to use with students in school:

*The Buddhist practice is good to encourage children to avoid drinking alcohol. This strategy will be easy to teach students in school, in contrast, it is very difficult for children who have left school early. Furthermore, this method should be provided in school because students obey teachers more than their parents. This is because teachers can give them a mark but parents cannot.*

She indicated that teachers could select an appropriate strategy to encourage students. Both teachers indicated that teachers at the school should encourage Buddhist practice amongst the students as a way of preventing them from drinking alcohol and should teach about morality:

*The students should be encouraged about the Buddhist practice at the school that can prevent them from drinking alcohol beverages.  
(Teacher 2)*

*In the past, there was a subject about morality to encourage students to avoid behaving badly and to foster information about morality. Nowadays, I don't know why there is no teaching on this subject; I think teachers should reintroduce this subject to encourage students.  
(Teacher 1)*

The teachers' ideas pointed to encouraging Buddhist practice in school as very necessary. It could encourage students to refraining from drinking alcohol. Teacher 1 commented on the revision of the curriculum by reintroducing the subject of morality in school, because this subject includes the concepts morality and being a good citizen which would encourage students to avoid bad behaviour and nurture morals in them.

### **7.8.3.2 Buddhist activities in the school**

The participants suggested that there were various activities within which Buddhist practice could be established. The secondary school students described how the school should arrange Buddhist activities with the Buddhist temple. *Dharma* camp (see more detail in section 7.8.4.4) was an activity that students would like their teachers to set up for them. The two students agreed with Student 3's opinion:

*We can use the Buddhist practice with students in the school, it cannot be used with children who no longer attend school as they are no longer under the authority of the teachers. The best program to help young people would be to have a Dharma camp. (Student 3)*

The students' views showed they needed a *Dharma* camp for encouraging them in Buddhist practice. The activities should be arranged for students in school because that was easier than Buddhist activities for children who were not in school, because of the teachers' authority. However, the police officer agreed with Parent 1 who indicated that school teachers should invite a Buddhist monk to give a *Dharma* talk at the school. She said: "*The school should set up a Dharma talk and invite a monk who has more experiences and tactics to encourage students*".

## **7.8.4 Buddhist Practice in the Temple**

The temple is the main source of teaching and training about Buddhist practice in Community C. The Buddhist monk is the most important person for encouraging people in the community to follow Buddhist practice. In the current study, the participants explained how teaching and training about Buddhist practice took place in the Temple; their perspectives are presented below.

### **7.8.4.1 Teaching at the Temple**

The Community leader claimed that the Buddhist monk should organize a program for young people by setting up a teaching programme entitled '*Sunday Dharma School*':

*We have Sunday Dharma School in Petchaburi Province that teaches about Buddhism, the Buddha's teaching, the Buddhist way,*

*and the Buddhist practice. I saw young people participate in this program, they will be well behaved and not drink alcohol and some of them become Buddhist novices. (Community leader)*

In support of this, the Buddhist monk showed that the best strategy for teaching should be to give the young people an example:

*If we want young people to clearly understand, we have to give them a real example. In this case, I invite a patient who got effects from alcohol as my co-speaker and then give young people an opportunity to ask questions. They like it, they ask a lot of questions. I think this can encourage them not to access alcohol. (Buddhist monk)*

#### **7.8.4.2 Dharma talk**

*Dharma* talk is a public discourse on Buddhism by a Buddhist monk or teacher. It is also a discussion based upon the reading and interpretation of Buddhist teachings. The policeman said that it was important for young people to listen to the Buddhist monk gave a talk in the Temple. The Buddhist monk always used simple words that young people could easily understand and it would be better if the monk gives a practical example. The policeman explained:

*We can use Buddhist practice to prevent alcohol consumption by young people. For example, Pra Payom Kalayano taught the Dharma with easy words that everyone can understand. Once he said if we put milk in one bowl and alcohol in another, do you know if a dog will drink the milk or the alcohol? It drinks the milk. A dog is an animal which knows the milk is useful for health. So why is it that we humans don't know what is best for us?*

The policemen described how *Dharma* talk could encourage young people to think about appropriate action. The Buddhist monk would give a proverb and clarify young people's problems which the police stated was very useful.

#### **7.8.4.3 Tamboon**

'*Tamboon*' is that which accumulates as a result of good deeds, acts, or thoughts and which carries over to throughout the life or the subsequent incarnations. Such merit



contributes to a person's growth towards spiritual liberation. *Tamboon* is a term denoting happiness, what is desirable, pleasant, dear and charming.

The students indicated that young people should make a merit on the important Buddhist days with various methods:

*The school teacher should take us to make a merit by offering food for monks at the temple on Buddhist days. (Student 3)*

*We should make a merit by chanting, doing meditation, we will know a lot of the Buddhism and the Buddhist practice. (Student 5)*

Excerpts from students showed that students knew about the way which leads to Buddhist practice. Student 3 said that students could make a merit by offering food for monks on Buddhist days. At the same time, student 5 said he should make a merit by chanting, and doing meditation. The two students' views were that young people relate to Buddhism by making a merit and believe in Buddhist practice.

#### **7.8.4.4 Dharma camp**

The Buddhist monk described how the *Dharma* camp is a very useful way to encourage young people to refrain from drinking alcohol:

*I have organised the 'Buddhabutra camp' with various activities. It is quite useful for children and they have been concerned about the alcohol effects and try to avoid them. (Buddhist monk)*

He explained that he set up the *Dharma* camp at his Temple called the '*Buddhabutra camp*'. He indicated that he organised a variety of activities for young people in this camp. As a result of the camp, young people will get interested and concerned about the consequences of alcohol and as a result of attending they will be motivated to try to behave well.

#### **7.8.4.5 Ordination**

Ordination was mentioned by parents who had children as Buddhist novices. Parent 2 stated that her son stopped drinking after he became a Buddhist novice. She said:

*“ordination is good. My son was ordained this summer, he has stopped drinking already”*. She had found an effective way to stop her child’s drinking, by taking him to temple and he got ordination. Similarly, Parent 4 has a child who became a novice for two years. She said: *“My son is in the same situation as that of Parent 2. He can stop drinking after he drank alcohol many years. He can stop drinking from two years ago until this day after he was ordained.”* She described how after his ordination her son stopped drinking and had now abstained for two years. In her view, ordination was an effective way to take her child away alcohol.

#### **7.8.4.6 Observing the Five Precepts**

Observing the Five Precepts of Buddhist practice is potentially an effective way to prevent young people from consuming alcohol. A precept is a rule or a principle that guides one’s moral behaviour. The Five Precepts involve:

- 1) Abstaining from the destruction of life – Do not kill,
- 2) Abstaining from taking that which is not given – Do not Steal,
- 3) Abstaining from sexual misconduct – Do not be unchaste,
- 4) Abstaining from false speech – Do not lie, and
- 5) Abstaining from fermented drinks and intoxicants that cause carelessness – Do not take drugs or alcohol

The parents indicated that The Five Precepts are good for daily life and young people should be encouraged to follow them. Parent 6 said: *“Buddha teaches us that drinking fermented drinks is a sin that we have to avoid. The adults can teach young people to follow this. If they practise following the Five Precepts, they can refrain from alcohol.”* Her comments concern the fourth precept of the Five Precepts which is to refrain from drinking fermented drinks. She noted that Buddha taught that drinking fermented drinks was a sin because it was a cause of carelessness. That was similar to Parent 2 who said: *“It is very good to use the Five Precepts to train children not to drink alcohol.”* She also indicated that if young people followed the Five Precepts, they could be dissuaded from drinking alcohol. In case of teaching the Five Precepts, Student 3 said that they should be taught by the senior Buddhist monk: *“if the adults*

*want to teach us about the Five Precepts, they should invite the senior Buddhist monk who has a lot of experience.”*

The Buddhist monk noted that drinking alcohol was not breaking the law, but it was a sin in Buddhism. It is regarded as bad behaviour in the eyes of Buddhism and therefore should be avoided by young people. Moreover, he said that the Five Precepts are principles to encourage young people away from carelessness:

*Drinking alcohol is not breaking the law but it is a sin in Buddhism. Please look at the statistics of the consequences of drinking alcohol. When people get drunk they have no consciousness. They carry out illegal activities, for example, killing, brawling etc. The Five Precepts principles encourage young people from being careless.  
(Buddhist monk)*

The director of the nursing school added that following the Five Precepts meant normal behaviour would become habit. If young people practise seriously, they will be happy:

*The Five Precepts is the concept of normal habit. If children practise seriously, they will be happy and not face problems. Moreover, fathers and mothers should teach them when they are young.  
(Director of the nursing school)*

She commented that young people who followed the Five Precepts as their normal habit would be happy. In contrast, if they omit to practise according to the Five Precepts, they are more likely to encounter problems. She also stated that parents should teach young people from childhood, so that they will understand the Five Precepts and practise them seriously.

Teacher 1 said that Thailand was a Buddhist country, children are taught about the Five Precepts by the family and then they are taught again by the Buddhist monks when their parents take them to the Temples:

*We are in a Buddhism community where children are taught about the Five Precepts from the family. When they go to the temples with their family, they will hear then again from the Buddhist monks. This can encourage them to understand and seriously practise, and they won't access alcohol. To refrain from alcohol drinking is one of the Five Precepts that we have been taught since being children. It is the best way to stop alcohol drinking. (Teacher 1)*

The teacher's words describe the two ways of teaching about the Five Precepts; at home and at the temples. Listening to the teaching many times can lead young people to understand and seriously practise the Five Precepts, and then they would not access alcohol.

These comments show that participants have explained the Five Precepts as the underlying concepts that can encourage young people to abstain from fermented drinks. Young people should be taught about this from childhood by their parents, teachers and Buddhist monks. Children who understand the concepts of the Five Precepts and seriously practise them will avoid committing a sin, by refraining from drinking. As the result of this, they will be happy and not face problems.

### **7.8.5 Reflection summary**

The Buddhist practice is useful to encourage young people from consuming alcohol. The participants recommended that the Buddhist practice should be the way to organize the intervention program for young people to control their drinking. In the current study, the participants have recognized the importance of Buddhist practice in various conceptual ways as follows:

- Buddhist practice as the Buddhist way
- The Buddhist Practice at the family
- The Buddhist Practice at the school
- The Buddhist Practice at the temple
- The Five Precepts

Buddhism is interwoven within the Thai community. Thai people respect the Buddha's teaching and pay close attention to practising and following the teachings. Like the majority of people in Thailand the people in Community C are Buddhists and they believe in Buddhist practice. People in this community believe that Buddhist practice can help to prevent their children from drinking alcohol. This suggests that the Buddhist practice can be used to design an intervention programme to help young people refrain from drinking alcohol.

## 7.9 Conclusions

Drawing on both the ecological approach to health promotion and the participatory action research framework, this chapter has explored the views and attitudes of participants using in-depth interviews and focus groups. It has examined young people's access to alcohol, the reasons driving young people towards drinking, the negative consequences of alcohol consumption, the strategies which could be developed in order to prevent young people from drinking, and the implications of Buddhist practice. The interviews and the focus groups were conducted with a number of stakeholders from Community C in Petchaburi Province, Thailand, and the sample included secondary-school students, parents and guardians, teachers, healthcare providers, a policeman, a community leader, and a Buddhist monk.

With regards to the issue of young people and their access to alcoholic beverages, the interviews and focus groups revealed that the ages at which young people start drinking has significantly fallen compared to previous generations. Drinking today begins amongst children as young as 10 and 11 years old. Furthermore the study has shown that, given that drinking at this age is not permitted, children started to develop strategies in order to access alcohol, or to enter into bars or pubs. The beverages young people prefer include beer, *Blend 285*, *Lao Pan*, and *Kra Chae*, which they often consume with their friends when there are no adults present. Drinking also occurs at parties, in public places, and at school.

The reasons driving young people to alcohol consumption are manifold. This study has pointed to several causes accounting for young people's drinking, namely their family environment, changes in family structure and lifestyle, and peer influence (especially those who left school early). Other causes include the desire to fit in to certain groups, the impact and influence of the community, the availability of alcohol due to the lack of restriction enforcement in community shops, and government policy along with the inconsistent enforcement of the Alcohol Act. Also, alcohol advertising and marketing was found to influence young people's behaviour and encourage drinking, so alcohol is reaching an ever-younger target audience. Another important finding consisted of the role played by culture, and particularly drinking culture, in

shaping the younger generation's attitudes towards alcohol. This is due to the present-day perception of drinking as modern, sophisticated, and generally socially acceptable.

The study has also revealed the consequences of drinking (low school performance, fighting, accidents), which call for the development of prevention strategies to be carried out at all levels. This includes within families, in schools, and within affected communities via policies such as the restriction of alcohol sales and advertising, and by raising awareness. Finally, Buddhist practices were discussed as a key element in the development of an intervention programme designed to prevent young people from drinking. The following chapter will provide a comprehensive discussion and interpretation of the findings revealed by the research.

## Chapter 8

### Discussion

#### 8.1 Introduction

In this chapter I discuss my findings in relation to the research questions identified in Chapter One. The research questions arising from my literature review and my professional background were as follows:

- What are the characteristics of alcohol consumption behaviour of young people in Thailand?
- What are community stakeholders' experiences of, and perspectives on, the alcohol consumption behaviour of young people?

The discussion uses the ecological model and developmental theories discussed in Chapter Three to interrogate the findings. The theoretical framework on which this study is built draws on the developmental psychology and socialisation theories, broadly in the approach suggested by McLeroy *et al.* (1988), known as the Ecological Approach Model. This model proposed by McLeroy *et al.* places a strong emphasis on personal development and the ecological factors that are likely to influence the development of an individual across the various levels previously described. This model is particularly useful in describing the attitudes of the young people towards alcohol consumption, and in providing possible explanations for the forces that drive them towards consumption, or even abuse, of alcohol at very young ages.

#### 8.2 Alcohol consumption behaviour of young people: Intrapersonal level

In accordance with the position adopted by McLeroy *et al.*, (1988), I set out to discuss the issue of alcohol consumption across the determined sample population by carefully considering intrapersonal factors likely to influence consumption of alcohol across the young population. The intrapersonal factors taken into account are the individual traits of a person, his/her intrinsic characteristics - which may impact the attitudes and behaviour regarding a series of events - and personal interpretations and beliefs.

According to professionals in this field (McLeroy *et al.*, 1988), intrapersonal factors may be used of healthcare professionals in their attempts to prevent disease and promote health.

Among the intrapersonal factors revealed as relevant for my study, one of the most pertinent indicators consisted of identifying the students' opinions and attitudes regarding alcohol consumption. In exposing them, I relied consistently on interactive methods such as focus groups and in-depth interviews with the target population, namely members of Community C in the Petchaburi Province in Thailand. The target population included in the study consisted of students enrolled in the secondary level, but also close relatives (parents), people taking over the responsibility of guardians (such as grandparents), advisory teachers, providers of healthcare services, as well as representatives of community bodies (a policeman, a community representative and a Buddhist monk) in order to provide a more comprehensive image of the situation of alcohol consumption as reflected in the selected population. Nevertheless, in this section aimed at discussing the intrapersonal factors involved in alcohol consumption among young people, the interviews involving the students, as well as the results obtained for the survey questionnaires will be the primary consideration.

At the intrapersonal level, several aspects are relevant to the issue of alcohol consumption at a young age. First and foremost, the age at which young people begin to drink alcohol is a very significant element. Both the interviews and the focus groups revealed that alcohol consumption began at the age of 10 - 11, sometimes even earlier (as argued by the nursing school director). This finding was in the direction of other similar studies in the field (Williams, Davies and Wright, 2010; Health and Social Care Information Centre, 2011, 2012, 2013; Henderson *et al.*, 2013; McClatchy, 2011), accounting for the decrease in the age at which young people start drinking. This suggests a worsening situation when compared to previous generations when alcohol consumption began, although still prematurely enough, at the age of 14 or 15. Even more so, as reported by the interviewed persons, the number of young people starting to drink at an earlier age seems to be an increasing trend.



When asked about the reasons which led young people to start drinking, however, the students' answers seemed to pertain to the interpersonal level rather than on an intrapersonal one. The students frequently mentioned the fact that they found out about alcohol in the family context – due to the fact that their fathers drank alcohol, an issue that will be further explored in the section below dedicated to interpersonal factors. This finding is consistent with the studies carried out by Henderson *et al.* (2013); Szmigin *et al.* (2008); Assanangkornchai *et al.* (2002); Chaveepojnkamjorn and Pichainarong (2007) or the SALSUS survey in 2008, 2010, and 2014 (Black *et al.*, 2008; Black *et al.*, 2010; Dodds *et al.*, 2014) reporting the family influence upon the children's drinking habits. Such behaviour could be explained by means of the psychoanalytical theory by which psychologists and sociologists have emphasised that every child has a unique history that accounts for physical and behavioural differences among all children (Berk, 2013; Gesell, 1933). According to this perspective, the unique sequence of events and the family background of every child shapes his or her personality. This can be extrapolated to the young people's attitude towards alcohol consumption which posits that the child's unique history is likely to account for their physical and behavioural development. Similarly, alcohol consumption among the younger generation may be assimilated to the ease of access these young people are experiencing, especially with the help of their older peers – an aspect equally pertaining to the category of interpersonal factors.

According to Freud's dimension (a series of developmental stages - from early childhood to adolescence), the first few years of child development are crucial for developing a healthy personality (Berk, 2013; Kail and Cavanaugh, 2008; Allen and Marotz, 2003), and the management of aggressive biological and sexual drives in this period sets up the overall personality of a child. A traumatic event occurring in childhood can turn into a trigger for delinquent or deviant behaviour (Martin, 2005). As in my study (Section 7.4.7), young people who have problems with a broken heart, grief loss and loneliness will use alcohol for reducing their tension, and some of them use alcohol because they wanted to encourage self-efficacy to do something more effective. This finding goes in the direction of the comments of Fletcher *et al.* (2009) that using substance was a result of trying to escape anxieties about school and was a

source of self-medication in response to exam stress or a constant sense of academic failure.

From an intrapersonal perspective, alcohol consumption seems to be determined by curiosity and by the youngsters' desires to experience new things. This could be related to the child development theories, extensively discussed in Chapter Three: social learning theory (Bandura, 1977), which explain the children's desire to experience and imitate the behaviours of the people surrounding them. As noticed in one student's statement, alcohol consumption in some cases began at very young ages – at around 10 - 11 years old – being driven by curiosity and facilitated by older peers. Some teachers argued that this early debut in alcohol use is explained by the generation gap and the differences in mentalities, especially when compared with the situation of a number of years ago. While previous generations were guided by a certain conduct and showed a rather reserved attitude towards their parents – “*they were scared of their parents*” (Teacher 1), the case is no longer valid for the newer generations, which enjoy more freedom and tend to have a different kind of relationship with their families. Following a similar theme, another factor contributing to the decreasing age at which teenagers begin to use alcohol resides in the fact that they nowadays have their own resources, either earned by means of part time jobs, or they are simply provided with money by their parents. Thus, this gives them the opportunity and the means to access alcohol at a very young age.

For the theories on social learning, young people acquire behavioural norms and norms of social conduct in both a direct and an indirect way (Bandura, 1977). Social learning theories are important for the analysis of the young people's attitudes towards alcohol consumption, as they provide insight into the youths' behaviour, and their tendency to imitate adults. Young people who observe family members or adults consume alcohol would copy their family members' behaviour as the role model to access alcohol and are therefore influenced by adults' behaviour (Smith, Cowie, and Blades, 2003).

According to Piaget (1971), children construct knowledge during their daily life experiences. The way in which young people interact with their environment is also transformed by their ability to plan and understand consequences of actions. This

indicates that the environment is one of the main influences in the development of deviant behaviour. In my study, students who experience adults' drinking consume alcohol after they observe the adults' behaviour in their daily life. Moreover, students actually use alcohol if they have close friends who consume alcohol, and particularly the finding in Section 5.11.2 shows that there is a statistically significant association between family members' drinking behaviour and students' alcohol consumption behaviour. Moreover, the finding in Section 5.11.11 also shows a statistically significant association between students' friends who have consumed alcohol and the frequency of students getting drunk.

These theories are further referred to in the discussion in the next section.

### **8.3 Alcohol consumption behaviour of young people: Interpersonal level**

Closely connected to the intrapersonal factors are the interpersonal ones. These are found to exert a great influence on young people's consumption of alcohol. As discussed in the literature on this topic (Gregg and O'Hara, 2007; Green and Kreuter, 2005), interpersonal factors refer to the factors and the processes which shape the dynamics making up primary groups. These groups consist of family members, relatives, friends, and acquaintances. Irrespective of the form these relationships may take (either meetings in person, or with the help of social networking web sites – which can be both formal and informal), they are a reflection of the individual's surrounding environment which can significantly impact his/her development. As a matter of fact, this environment greatly contributes to building the individual's behaviour and attitudes, and it seems also to play an equally significant part in developing young people's attitudes towards the issue of alcohol consumption (Gregg and O'Hara, 2007; Green and Kreuter, 2005).

This study has reaffirmed that the age at which alcohol consumption begins has dropped significantly as compared to a few generations ago (from the age of 18 to the age of 11), while also pointing to a series of possible causes for this reduction. These causes can be included in the category of interpersonal factors and will be described below.

At the interpersonal level of McLeroy *et al.* (1988), several types of relationship are considered relevant and as having an impact upon the development of young people. Family is perhaps the most important connection, and, as revealed by this study, it appears that alcohol consumption begins very often, in an informal way, within the family environment. Moreover, several studies recommend that parents are usually thought to be role models that children look up to and try to copy (Brown *et al.*, 2008; Donovan, 2004; Kask, Markina and Podana, 2013; Sieving *et al.*, 2000; Van Der Vorst *et al.*, 2006). The data gathered from the interviews that I conducted further supports the view that the parents' behaviour influences young people's attitudes to drinking. In what follows, two important categories of interpersonal relations will be detailed. The first refers to the fact that very often, the young people's drinking problems associate with the family members' drinking behaviour particularly father's and sibling's drinking. The second then shows how peers have a very strong influence upon young people's behaviour, with peer pressure being another triggering element for alcohol consumption.

From this it can be seen that family has been clearly identified by the participants in the study as one of the most significant elements responsible for shaping the dynamics of alcohol consumption across the younger generation. This factor is likely to have an even stronger impact in cases where family members make use of alcohol, thus setting a negative example for the younger members, who are at times tempted to mimic their behaviour. Both the young participants and the adults confirmed the impact that family behaviour is likely to have on the youngsters' attitudes and conduct. This can be explained by the fact that, more often than not, family members – and, more particularly, parents – are seen as role models in the eyes of their children. Moreover, they are supposed to provide children not only with their personal example, but also with a set of values to guide their development into adulthood, in the same way as school does. As a matter of fact, as explained by the community nurse, the responsibility for teaching children how to behave – at home and outside home, in social contexts – belongs to the parents. They are the ones who are expected to explain and teach the morally and socially accepted modes of conduct, primarily by setting an example, and by explaining the negative consequences that alcohol consumption may have on people's lives.

Nevertheless, while this is the expected behaviour it is not always the observed. My study has shown that very often fathers do not refrain from alcohol consumption in front of their children, thus providing a negative example that their young children tend to imitate. This view is supported by both the community nurse and the nursing school's director, who have identified numerous cases where the parents' habits of alcohol consumption was underlying similar behaviour observed in the children. This mimicking behaviour is explained by the participants in the study by the fact that, exposed to the example set by their parents, the children are driven by curiosity and tend to be tempted to imitate them.

Furthermore, as revealed by some of the students included in the study, their parents' attitude is often confusing, as Student 2 described:

*Parents say alcohol is bad but they drink as an example for young people, particularly the father. The father usually drinks and then he teaches his child not to drink. This can make children become confused. We want to copy this because we want to know what alcohol taste is and we don't know about the consequences.*

From Erickson's point of view about the stage of identity versus role confusion, adolescents are faced with solving life 'crises' that are connected to developmental stages. When they manage their crisis successfully the result is a clear perception of individual identity and readiness to share this identity with others (Berk, 2010). As the above quotation shows, parents tell their children that drinking alcohol is not good for their health, but they do not adhere to that guideline themselves. Therefore, seeing their parents drink, young people fail to acknowledge the real dangers that alcohol consumption is likely to bring. This opinion is confirmed by the specialists' view, who argue that children will naturally follow the examples set in practice by their parents, be that a good or a bad one. Furthermore, some of the parents gave evidence supporting this perspective, providing the conclusive example of their own family, in which the father's drinking habits – manifested in front of the children – ultimately led to the children acquiring a similar behaviour.

The attitude towards drinking is made explicit to the young people by means of rules of conduct and social expectations as well as the overall consequences they are likely

to have for the entire family and household. It is clearly showed that young people are presented they consumed alcohol at a very young age, even before entering the adolescent stage. Consequently, parents should discuss directly with their children about acceptable conduct, including as regards the consumption of alcohol (Windle, 2000).

The data collected from the interviews and focus groups are congruent with other studies dedicated to this topic, (Gill *et al.*, 2012; National Statistics Office 2005; Thamarangsi, 2006; Assanangkornchai *et al.*, 2010; Assanangkornchai *et al.*, 2002; Sieving *et al.*, 2000; Van Der Vorst *et al.*, 2006), which revealed that young people tended to take up drinking habits if they lived with someone who also consumed alcohol. This state of affairs leads us back to the theories on child development (Berk, 2013), which are likely to account for the urge that drives children towards imitating the perceived behaviours. The changes that occur in the development of teenagers have a significant impact on future behaviour, and the cognitions play a significant role in the generation of emotions which influence behaviour. This connects directly with the childhood period when the parents' response to the children's behaviour is very important in how they learn to perceive the expression of emotions and habits.

According to social learning theories, children imitate everything in the beginning but then gradually become selective in the process of growing up (Coleman and Hendry, 1999; Goswami, 2008; Slater and Bremner, 2003; Slater and Muir, 1999). Regarding my study, participants agreed that children provide insight into their tendency to imitate adults who they observe or live with:

*Young people's behaviour depends on their family members, if their family members are good example, they will follow. At the same time, if their family members make a bad example they will copy that too. (Community leader)*

*My child drinks alcohol after seeing his father drink at home. At first, he got alcohol from his uncle, after that he drinks almost every day. (Parent 8 and Parent 3)*

It can thus be argued that most participants in the study agreed with the view that one of the most important interpersonal factors leading to alcohol consumption among

members of the younger generation lies in the example set by the closest relatives – more often immediate family members, and especially parents. Often seen as role models by their children, parents are the persons who young people observe and would copy. Moreover, the practices and communication within the family can motivate young people's decision to abstain from the consumption of alcohol.

Aside from the personal example they set, family has been identified by the participants (e.g. Community leader, Community nurse, students) as having an effective role in shaping the behaviour and the conduct of the young people. Therefore, a united family is likely to foster a better environment for children's development as compared to single parent families as shown in Section 7.4.1.2. Once again, the family structure nowadays was compared by the participants in the study (Director of nursing school, Community nurse) with the family as it was a few generations ago. The adults included in the focus groups reached the conclusion that the changes occurring in the family structure seem to be following an upward trend (more single families) and this constitutes one of the factors leading to the undesirable behaviours that children manifest, alcohol consumption being but one of them. This was commented on by community nurse:

*Nowadays, people like to live as a single family, and teaching in the family is disappearing which is different from the previous generation when parents usually taught their children every night ... Nowadays, father and mother do not have enough time to talk and play with their children, they spend a lot of time earning and working.*

Moreover, in the participants' opinion (e.g. Parent 5, Director of nursing school, Community nurse), the economic environment characterising the world we live in today has led to deep transformations in both the family structure and its organisation. Forced to take up two or even more jobs in order to provide for their families, parents described a situation where they spend increasingly less time interacting with their children and so are less involved in their education by default. This indirectly leads to an increase in the time that children spend on their own, on the Internet, or on social networking sites, in other words, the economic transformations defining the present-day environment seem to have deepened the gap between generations, and this is likely

to have impacted with serious consequences on the development of the younger generation. Moreover, lack of communication between parents and children has been identified by the participants (Community nurse, Parent 5) in the study as yet another constant characterising the interpersonal relations that young people are involved in. This segregation, together with the availability of the new media, leaving the children with no authority figures to help them to make the right choices, seems to contribute to the increase in the number of children who start drinking alcohol, partially accounting for, at the same time, the lowering of the age bracket in which alcohol consumption begins. This can be supported by the literature reviews of the studies of many researchers (Ellickson *et al.*, 2005; Hornik *et al.*, 2008; Mackey, Liang and Stratthdee, 2013; Smith, Cowie and Blades, 2011) who have explored the significance of media for altering adolescents' behaviour in respect of substance abuse. This is similar to Velleman (2009), Grube and Waiters (2005), Winpenny *et al.* (2012), and Winpenny, Marteau, and Nolte (2014) who explored media and advertisements as major impacts on young people's attitudes and behaviour towards alcohol use. Nevertheless, the participants in my study also commented on this aspect:

*I have to work hard in the rice field and have not enough time to teach my son because I don't meet him when I came back from work. I don't know what my child needs, he only plays with the computer. Sometimes we never talk to each other. (Parent 5)*

*When my son finishes his school, he usually spends a lot of time in his room and surfs the Internet. (Parent 8)*

According to the responses of the community representative, young people need role models to look up to, people they can learn something from, people who can help them to decide what is good and what is bad for their development. On the other hand, in the absence of such models, in the absence of a family who knows how to guide them, young people may resort to alcohol, or other alternatives to escape their unhappy family environment. As it is posits by the participants:

*I don't like when my father and mother has argument and then my father drink alcohol after argument. I also use alcohol to decrease this tension. (Student 4)*



*My father never teach me don't to consume alcohol in contrast, he drinks in front of me. (Student 3)*

As posited by the students this is evidence showing that the environment in the family and teaching by the family members are important to motivate them from alcohol consumption. It is similar to the studies of Vantamay (2009), Assanangkornchair *et al.* (2002) and Chaveepojnkamjorn and Pichainarong (2007) who stated that the young people see how parents can act as sources of information and models for educating their children with regards to the use of alcohol. However Thai parents do not often provide the best education or advice surrounding alcohol use. Parents do not often act as good role models for their children, on the other hand, they often are the root cause of their children's drinking patterns.

Alcohol consumption, and unfortunately abuse, among young people has been commonly perceived as a problem of these current times. In accordance with the results and findings provided during the interviews, there are a series of interpersonal factors which are likely to push young people into turning to alcohol in order to cope with depression or pressure. This series of risk factors comprises the family effect, and more precisely the "broken family" aspect, and the influence of peers, considered within two distinct contexts: peers in school, and peers who left school early for various reasons.

Furthermore, a hierarchy can be established regarding these interpersonal factors. A group of the parents who participated in the interviews frequently acknowledged that a family with only one parent - the other being lost either through legal separation or death - is a broken family or a broken home. Unfortunately, death and separation are very likely to result in pressure on youngsters, and almost always such circumstances lead to depression. For example Parent 1 explained:

*Broken family is an important point affecting young people drinking...after my grandnephew's mother separated she did not have enough time to care for her child, she drank a lot and always on the phone to her new boyfriend. This is a bad example that my grandnephew may copy his mother's bad habits.*

Most young people who turn to alcohol consider that this substance will help them cope with the new defective environment and also compensate for all losses (the finding from the survey in Chapter Five, Section 5.10.1). Essentially, any change in the structure of the family is compounded with the duality of causing complementary issues. In most cases, children whose parents had divorced spend an increased amount of time in the company of peers who do not attend school.

*My child's mother and father were divorced and nobody took interest in him. Though, he spends a lot of time with his friends, particularly friends who do not attend school. This problem also occur with the neighbours' children near my house too. (Parent 1)*

A worsening consequence of separation is that it may cause financial problems for both parents. Money is likely to mentally stress or depress separated parents and by being forced to work extra hours, parents have less time to spend with their children (as shown in Chapter Seven, Section 7.4.1.2). Parents' lack of spare time can lead to internet dependence, bringing young people one step closer to accessing alcohol. Moreover, single parents may turn to drinking alcohol in order to deal with the sadness and the stress they are experiencing, thus inadvertently setting a bad example for their sons and daughters who may be likely to copy this ill habit. The child development theories, such as the psychoanalytical theories, or the social behaviour theories (Berk 2013; Crain, 2005; and Thomas, 2005), are conclusive at this point, explaining the impact that the structure of the family, its soundness and its degree of cohesion may have on the development and the behaviours of children.

An interesting aspect emphasized by the findings refers to the participants' points of view concerning the relationship existing between the family effect and young people's consumption of alcohol. In many cultures, the family is the essential teaching source for children, focusing on providing them with the best example in order for children to become responsible persons. As parents are their children's models, it is in their power to teach them how to grow up and become educated adults. Thus, drinking alcohol in front of children is likely to result in children copying this practice sooner or later in their lives. However, children would most probably refrain from consuming alcohol, as well as any other harmful substances, if they were fully taught the negative aspects of such bad habits.

The second interpersonal factor causing alcohol consumption and abuse among young people is the influence of peers. For the purposes of this research, the interviewees were divided into two categories, one comprising individuals who were then in school, and the second category comprising individuals who had left school at early ages. Both are considered to have an effect on young people in what influences their consumption of alcohol.

Furthermore, according to the findings from the survey and the interviews, students who were in school also acknowledged that they started drinking alcohol after older students offered it to them. Senior students would also show younger students how to mix alcohol with other drinks. The juniors' decision to consume alcohol was very much influenced by their conviction that by drinking the alcohol offered by a senior, they would earn their respect and thus would not be bullied or attacked later in school or outside it. Unfortunately, it seems that junior students are persuaded to drink for fear of not being reviled by senior students. These findings regarding peer pressure or peer influence on alcohol consumption correlate with results obtained in other studies (Foxcroft *et al.*, 2003; Jones *et al.*, 2006; Cole, Cole and Lightfoot, 2005; Velleman, 2009; Webster, Hunter & Keats, 2002), reaffirming the role that friends and peers may have in shaping the young people's behaviour. Peer influence can be traced again back to the child development theories (Berk 2013; Crain, 2005), revealing this kind of behaviour as an escape from a world in which the child does not feel safe or understood by his/her family, which seems distant and distanced and in which the child seeks understanding in their peers. Furthermore, the desire to be acknowledged, the desire to integrate within a group and to be appreciated can be accounted for by means of the psychoanalytical theories (Berk, 2013), and the influence of the family background and the child's early experiences as an answer for their later behaviours.

In addition, graduation parties are, in the opinion of some of the participants, another possible context where students may be tempted to try alcohol. While the senior students are old enough to drink alcohol, the fear of not being included in their group, the desire to correspond to the senior students' expectations, or the desire to 'be one of them' may encourage junior students to drink alcohol, as a means of social integration. Furthermore, as argued by school representatives, these parties where

alcohol consumption is allowed seem to be more frequently organised, giving young students the opportunity to access and try alcohol on an almost regular basis. This points to the fact that the interpersonal factor of peer relationships turns into an almost intrapersonal element; in other words, driven by their desire to integrate, to be part of a particular group, young persons may be tempted to imitate them, almost subconsciously.

Thus, an important factor likely to contribute to an early debut of alcohol consumption resides in the influence that students have on each other. From this perspective, as revealed in this study, the influence of the students with poor school results, or even those who dropped out of school, is even more detrimental to the development and the behaviour of those who are still in school. Even more so, adherence to an undesirable behaviour is dictated not necessarily by the fear of not being accepted in a group, but, worse, by the fear of not being hurt, or assaulted.

As also revealed by this study, a low education level among young people is likely to lead to a higher alcohol consumption rate. Both the parents and the school representatives confirmed that students who dropped school prematurely are likely to be drawn towards alcohol consumption and to try to convince their friends to behave in a similar manner. This correlates with other studies in the field (Chaveepojnkamjorn and Pichainarong, 2007; Hallfors *et al.*, 2006) on the connection between academic performance and alcohol consumption.

Thus, it can be argued that interpersonal factors play a considerable role in shaping young people's behaviour and, therefore, they can influence alcohol consumption in the younger generation. Therefore, prevention measures should be set up by both the family and the school representatives who should get involved and take direct action towards the promotion of health among younger generations and the prevention of alcohol abuse (especially at an early age). Furthermore, more resources should be allocated in schools and educational facilities with a view to raise awareness on these matters among both the children and their family members. Nevertheless, all the factors involved in an individual's development are interrelated; hence, any action

taken will only be fully effective when correlated with the other players involved at community, institutional and policy level.

#### **8.4 Alcohol consumption behaviour of young people: Institutional (organizational) level**

As discussed in the literature (McLeroy *et al.* 1988), the norms, the rules and regulations, and the procedures according to which a particular community functions are deemed to have a strong influence on the behaviour, the attitudes and finally the general conduct of its members. In other words, the social environment (be that the workplace or the education environment, for example) is likely to impact an individual's attitude, dictating (consciously or not) his or her own behaviour. Therefore, given the strong influence that organisations have on their members' behaviours, specialists advocate for the organisations' involvement in the promotion of a more active attitude and the support of awareness-raising campaigns, with a view to impact the members' behaviour positively (McLeroy *et al.* 1988).

In terms of institutional or organizational factors considered in this analysis, the school is deemed to play the most important part in shaping the students' attitude towards drinking. In addition, my findings demonstrate that parents in Thailand seem to have high expectations from the teaching staff with regards to the information they should provide the students about alcohol consumption. Therefore, the discussion on the institutional factors involved in the young people's consumption of alcohol will be centered on a series of aspects including: the connection between the school environment and alcohol consumption, the adequacy of the school curriculum and the significance of alcohol and substance misuse education, as well as the importance of developing and implementing prevention measures.

As revealed by the research carried out by means of the focus group and the in-depth interviews, the curriculum, and more extensively, the school environment are considered by both the teachers and the students to be a high-impact factor likely to

affect the young people's attitudes towards alcohol consumption. This finding, congruent with other research in the field (Valente *et al.*, 2007) supports the view that the risk of alcohol consumption or abuse among students can be mitigated by placing more emphasis in schools on the promotion of health and the negative effects of the use of alcohol (and other substances) and with cooperation between school and family. The teachers in my study argued that too often the issue of alcohol consumption was disregarded and considered secondary to other problems such as substance abuse or 'unsafe sex' when in fact they perceived that alcohol is, more often than not, the underlying cause for behaviours such as these.

The same opinion was also shared by the students included in the interviews, who argued that they were not provided with enough information regarding the negative impact that alcohol consumption is likely to have on the development of young people. Furthermore, as indicated by the interviews conducted on the sample population (e.g. Student 2, Student 3, Student 4, Student 6, Teacher 1, and Teacher 2), it seems that classes on the promotion of health and the negative impact of alcohol consumption or drug abuse are restricted to a single class per week at secondary level. Besides the fact that one hour a week seemed insufficient to the students, they also argued that such instruction should begin much earlier, considering the fact that alcohol consumption begins as early as primary school.

From the same organisational perspective, the interviews have additionally revealed the fact that the teachers themselves sometimes fail to provide the expected example. Offering the students a negative model of behaviour (e.g., by drinking alcohol after finishing the classes) that students would copy, as the Buddhist monk described:

*Sometimes teachers teach the students to avoid alcohol but they themselves drink in the evening when they finish their work...this is providing an example that students copy.*

Given the importance that school and educators have on the development of children (Valente *et al.*, 2007; Shears, Edwards and Stanley, 2006), it can be argued that, especially at young ages, it is important that teachers and family are giving the same messages. This reflects the Thai cultural norms where the teacher is understood as the 'father and mother' at school, and teachers are expected to look after the child as their

own. From this perspective, not only parents, but also educators, are often seen as role models, and should behave in such a way that their conduct does not harm the later development of the young students.

From the point of view of child development theories, the formal operational stage (11-15 years) is the last stage which is equivalent to the adolescence period (Piaget, 1971). According to this stage, hypothetical thinking and scientific reasoning are developing in this stage along with the ability to plan and understand the consequences of one's actions. This means the stage where the children are mature enough to make their own decisions and dissociate between the good and the bad (Berk, 2013), where they take up the perceived behaviour (Bandura, 2001), which accounts for the importance of providing good examples both at home and in school.

Equally, while the students' presence in school correlated with the health promotion teaching, and the teachers' own efforts to raise awareness on the negative effects of alcohol consumption were also revealed by the study as important prevention measures, several shortcomings were identified too. Among these the most important concerns were rooted in the inadequacy of the school curriculum which is yet to be adapted to the new educational needs, as well as being manifested in the fact that instruction regarding alcohol use should be provided as early as the primary school years. Therefore, besides the modifications in the school curriculum with an increase in the attention and care paid to alcohol-related education and instruction regarding the negative effects of alcohol, more attention should equally be paid to the strengthening of Buddhist education in school, and the introduction of Buddhist activities (*Dharma camp, Dharma talks*).

## **8.5 Alcohol consumption behaviour of young people: Community level**

The next level considered in this discussion is that of community action. As previously discussed in the literature review, it is argued that the community – with its constitutive elements – contributes significantly to the development of its members, holding the power to effect positive behavioural changes, including in matters related to alcohol and substance abuse (McLeroy *et al.*, 1988).

Several social organisations and institutions are in charge of the development and execution of programmes aimed at promoting health, and rightfully so with community power extensively discussed as having a positive impact on the prevention of alcohol consumption and substance abuse not only at a national, but also at a worldwide level (WHO, 2014). The community is a powerful external factor referring to social norms or culture, physical availability, and the price of alcohol (Ahlström and Österberg, 2005). Social norms, the most reliable predictor for young people drinking, is their friends' drinking habits and family members' drinking. Moreover, the parent-child relationship, communication and practices also influence young people's alcohol consumption. Culture influences how much teenagers drink. For instance, young people who live with community members who drink were more likely to consume alcohol more frequently than adolescents elsewhere (ICAP, 2014). Alcohol availability and pricing is also an important factor. For example in European countries where the Minimum Legal Drinking Age (MLDA) is 18 years, young people can access alcohol earlier than several countries (such as the USA and Indonesia) that do not allow young people to consume alcohol until they are 21 years old. Moreover, a high alcohol tax is an effective policy for controlling alcohol consumption among young people as well as strict regulation of the sale of alcohol with limits of locations and times (Ahlström and Österberg, 2005).

This study has revealed that several actors (community leaders, providers of healthcare services, or the Buddhist monk) are involved in enhancing health at a community level within the Petchaburi Province, Thailand. These actors have worked collaboratively to raise the awareness of both students and their parents with regards to the negative impact of alcohol consumption. Their actions have involved the organisation of trainings and workshops, as well as awareness-raising campaigns directed towards a series of problems adolescents are currently confronted with.

In this study, I started with the assumption that at community level all these actors should be actively involved in order to address the manifold health problems adolescents are increasingly faced with. To do so, this study relied on focus groups and in-depth interviews with the stakeholders, in an attempt to answer a series of questions regarding the young people's access to alcohol within the community, the



possible implications that the community might have on their predisposition to drink alcohol, the role that the community plays in promoting health and in raising the young people's awareness regarding the danger of alcohol consumption, the role of religion and the extent to which it could influence young people not to use alcohol, as well as possible strategies to prevent consumption among the youth.

While alcohol consumption is an accepted social practice in Thailand, it may however, have a negative influence on the younger generation. Thus, this study has tried to present the effect that alcohol-related community practices have on the young people's own attitudes and conduct regarding alcohol. Consequently, as revealed by the interviews and focus groups, one possible cause for the young people's drinking habits seems to consist precisely in the example set by the adults living in the same community. Additionally, another important element that seems to have contributed to the youth's alcohol-related conduct is the fact that they are exposed to and have easy access to alcohol, since community shops will sell alcohol to young people (Ahlström and Österberg, 2005).

With regards to the first aspect concerned, as pointed out by the interviewees, in Thailand men are allowed to drink alcohol at any time, a practice accepted - and regarded as the norm - at the level of the community. This is increasingly adopted by the younger generation and, as pointed out by the community nurse interviewed, this behaviour does not seem to concern the adults within that respective community. Moreover, they still deem this behaviour as inscribed in the norm. These findings allow the inference that, since the generally accepted view is that drinking alcohol is normal within the Thai community, it is only natural for young people to adopt the same behaviour and thus start drinking at a very young age which they think is smart behaviour and some adults offer them alcohol to try, to quote Student 4, "*Children think it is smart if they can drink alcohol like adults do*". This opinion was reinforced by the interviewed students themselves, with the interviews revealing that students do not seem to see any impediment in their alcohol consumption practices, to quote Student 3, "*there is no regulation to say young people cannot drink in our community*". And, even more a reinforcement of this opinion, the adults themselves sometimes offer alcohol to young people, especially at social events.

With regards to the concern over the access that young people have to alcohol, the interview data identified that the community shops – the grocery stores – provide an easy access to alcohol for young people. Many shops are open 24 hours a day seven days a week and there is no impediment to the young people buying such products. This allows the conclusion that the high rate of alcohol consumption across the younger generation in the community chosen is in fact facilitated by the community itself. Even more so, the data shows that adults very often send the younger members of their families to community shops to buy alcohol. On the one hand, this points to a high level of exposure of the young people to alcohol products. On the other hand, although shop assistants should not be allowed to sell alcohol to the underage, more often than not there is a simple explanation from the children as the participants comment:

*...One cause of young people being able to drink is that they are innocently sent by a family member to buy alcohol from the community shop for older family members. The first time, children will tell the shop keeper that it is for their parents. If the shopkeeper accepts this explanation as legitimate then he will probably sell the alcohol to the young person. (Buddhist monk, Community nurse)*

*Most shop owners in the community sell alcohol to children. They never ask for ID although they know the age of the buyers is less than 20 years. We can buy alcohol because we are familiar with the owners and we used to buy alcohol for our parents. (Student 7)*

This conclusion is provided by the students who stated they had not been asked for any form of ID when they had attempted to buy alcohol. As revealed by the interviews, this state of affairs is sustained on the one hand by the lack of police controls in the shops and, on the other, by the fact that most shop owners/shop assistants are familiar with the underage drinkers in the community and they have no problem selling alcohol to them, although they are aware of the fact these individuals are below the legal age.

Furthermore, as also indicated by some of the survey participants, specifically the community leader and the nurse, this shows a lack of interest by the shop owners, who do not realise (or do not care about) the possible negative implications that alcohol consumption is likely to have on the young people. They seem to be more interested in the profit that selling alcohol brings to their business. Bearing this in mind, the

investigations carried out in this study have revealed that almost all elements of this research community may contribute a negative factor to the development of the youth in the respective environment, from family members providing a bad example and even offering alcohol to the young people, to the shop owners failing to comply with the regulations in force and to refrain from selling alcohol to underage people. This widespread behaviour at community level is likely to have deep implications at the policy level, impacting the development of policies regarding alcohol consumption, which will be further explored in the following section on the policy level of young people and alcohol use.

It can be argued therefore that, when discussing sensitive issues such as alcohol consumption across the younger generation, there is no unique factor leading to that respective state of affairs. There are instead a variety of interrelated factors converging to a given result.

Thus, while this study has revealed the fact that alcohol consumption by the young people in the community under analysis is due to a certain loss of the children's self-restraint and control, this loss of control can be interpreted as a consequence of the adult behaviour that the children experienced and began to internalise. From the perspective of the child development theories (Cairns and Cairns, 2006; Berk, 2013; Sternberg and Jarvin, 2003), children at an early age (under 11 years old) still lack the ability to critically distinguish between which actions are good and which are bad (Piaget, 1971), and they are tempted to imitate all adult behaviour to which they are exposed. This conclusion is supported by the nurse's interventions, who posits that the children, witnessing adults drink alcohol, considered this to be the accepted conduct and started to imitate it.

Another outstanding factor contributing to the development of this behaviour from the children is the family background. As presented in Section 8.3, this factor is equally based on the community, or, more precisely, on the position that a particular family occupies within the community it belongs to. Cases of alcohol consumption at a young age are, more often than not, relegated to families with low income and poor status within the community, who fail to provide good examples to its younger members.

Another factor which pertains to the community level in this analysis is that of culture. As revealed by the data, culture seems to be among the elements that are likely to trigger such conduct from the younger members of the community who are so broadly exposed to alcohol consumption including during cultural or even religious ceremonies organised by the communities they belong to. As posited by the community nurse interviewed, alcohol consumption during the various ceremonies organised by the Community C – such as *Sen Reun* – is part of their cultural heritage, and it is supposed to bring them good luck. Young people are exposed to such manifestations, during which they are not only invited to take part in, but also to drink alcohol.

Furthermore, since culture occupies such an important place in the life of the community, it is imitative for the young people to adhere to this unwritten code of conduct accepted throughout the community. Similar studies (Valente *et al.*, 2007; Velleman, 2009) have also pointed to the impact of culture on the behaviour of adolescents, influencing their attitudes towards drinking, smoking, drug abuse or delinquent behaviour. From this stance, prevention strategies which have been broadly tackled by other researchers (Mulvihill *et al.*, 2005; Harrop *et al.*, 2006; Taylor *et al.*, 2007; Stigler *et al.*, 2006) could be directed successfully towards raising the young people's awareness in matters related to alcohol consumption. My research has revealed the need for strengthening a community network that should focus on setting good examples and creating youth clubs to foster positive attitudes, behaviours and conduct as noted in Chapter Seven, Section 7.6.3.

## **8.6 Alcohol consumption behaviour of young people: Policy level**

Finally, the last level of this discussion is concerned with the policies that are likely to impact the promotion of health within a certain population. Developed within the same ecological approach described previously in this thesis, the policy level is inscribed along the same lines with those already discussed, and it operates in close connection with the intrapersonal, interpersonal, institutional/organisational and community levels (McLeroy *et al.*, 1988). As described in the literature review, the programmes designed for health promotion and social intervention are built on a set of common

values and beliefs shared by a given community, on the individual members' understanding and interpretation of given problems, as well as on factors drawing on the cultural heritage and the public policy tradition in that respective environment.

As already seen in the literature review, it seems that the government of Thailand has attempted – from as early as 1999 – a decentralisation of its basic functions in the hands of local administrations (Wibulpolprasert, 2005), thus leaving the services as the responsibility of the local authorities. Therefore, local administrations should take up the responsibility of controlling and assessing cases of alcohol consumption and misuse at community level.

Measures in this direction are taken with the help of police representatives, who have reported an increase in juvenile crime rate, which they attribute to alcohol and substance abuse. This accounts for the views – in the interviews carried out as part of this study – of a police representative, with a view to drawing some conclusions regarding the stance taken by the policy makers regarding several issues relevant to my study.

As described in the complaint by the head nurse, the policy makers have formulated The Alcohol Act but do not enforce it. The police usually take action not consistently, only at special festivals, and the policy makers never check that the policies are being carried out. Furthermore, there are insufficient staffs for monitoring whether the Alcohol Act is being complied with in the community. Another concern is that there are no government restrictions on the type of sponsors or advertisers at stadiums and sporting events and that the companies supply alcohol for the winning celebrations. This leads the sportspersons and supporters, who are mostly young people, to accept this behaviour and usually use alcohol to celebrate winning.

Other concerns centred on the strategies and measures taken to mitigate the risks, as well as the policies involved. Some studies have been dedicated to the issue of alcohol consumption by underage drinkers (ICAP, 2013; Harrington, 2000), which contravenes the legal provisions in force. The International Center for Alcohol Policies shows that lawmakers have implemented policy strategies that focused on: reducing alcohol availability for young people, restricting commercial access, regulating the

content of alcohol advertisements and its exposure to young people, reducing economic and social access and raising the Minimum Legal Drinking Age (MLDA). These policies are effective in reducing alcohol consumption among young people. Harrington (2000) studied the enforcement of policies but found that it was ineffective, because young people can purchase alcohol and only a few retailers refused young people's alcohol purchasing.

One important aspect at policy level refers to the fact that, as reported in the interviews with some of the participants (e.g. Head nurse, and Parent 1), while an 'Alcohol Act' is currently in place in Thailand, the authorities fail consistently to enforce it. As argued by the study participants (Student 7, and Student 8), policemen fail to control the commercialisation and use at the level of the Petchaburi Province, which forms the basis of part of the alcohol-related problems experienced by the younger generation. The same view is shared also by the students, who confessed they had absolutely no problems when they attempted to buy alcohol from community shops, since no police representative ever asked for their ID. The participants further argued that action is only taken – if ever – during special events, and even then, the police are understaffed. This view is further supported by police representatives, who argued that they could not adequately cover the areas within the community on a regular basis. The lack of sufficient resources and measures taken to reduce the alcohol consumption among the young people seems to be one of the causes of dissatisfaction across the population interviewed, who complained about the ineffectiveness (or even lack) of the anti-drinking campaigns organised not only at a local, but also at a national level. In their opinion, if organised on a regular basis, such campaigns could contribute significantly to a decrease in the number of cases of drunk-driving and subsequently in the number of accidents caused as a result of alcohol consumption.

This leads to another finding found in this study. As posited by the interview participants (Head nurse and Community nurse), advertising constitutes yet another cause for the increase in the rate of alcohol consumption across the younger generation. Alcohol production companies are frequently the main sponsoring bodies during sport events, displaying their brand names everywhere and heavily advertising their products. In addition, as the interviewees (Healthcare providers) argued, they

supply alcoholic beverages for the events organized in celebration of the competitions, encouraging this behaviour among the supporters and in the audience of the sporting events. Most of the time, the audience is composed of young people, and the heavy advertising of alcohol is likely to have a strong impact upon them, as it is designed to do.

The interviewees have reached a strong consensus regarding the impact that advertising has, as well as the advertisements' power to persuade and influence buyers, especially when it comes to young people. As pointed out by the community leader, the development of new technologies has increased the young people's access to advertisements and commercials which promote alcohol. Children are incessantly exposed to websites, films and videos which show celebrities in scenarios likely to involve alcohol. The general consensus reached by the participants in the study was that the young people's high exposure to the new media and the new means of communication is likely to contribute to the increased rate of alcohol consumption across this age range. This is similar to the findings in studies by Ellickson *et al.* (2005), Hornik *et al.* (2008) and Mackey, Liang and Strathdee (2013) which explored the significance of media in altering adolescents' behaviour in respect of substance abuse. It also supported by Velleman (2009), Grube and Waiters (2005), Winpenny *et al.* (2012), and Winpenny, Marteau and Nolte (2014) who have explored how media and advertisements are major impacts on young people's attitudes and behaviour towards alcohol through the media (film, music, magazines, social network), advertising and marketing.

Thus, the participants in the study agreed that an alcohol policy, properly enforced, could become an important tool in the prevention and control of alcohol consumption but that at present, no measures were taken for the correct implementation of the existing legislation. Moreover, in the absence of stricter rules and regulations, the young people's access to alcohol is facilitated. The interviewees emphasised the need for greater police involvement in policy enforcement in order to control the activity of shop owners and pub managers, and thus reduce the rate of alcohol consumption amongst the young people. With regards to the impact of advertising, an "Alcohol Act" could include provisions regarding alcohol promotion through commercials and other

means of online or offline advertising methods, as this appears to be one major concern in relation to the young people's access to alcohol.

This correlates with other studies (Cuijpers, 2003, 2005; Foxcroft *et al.*, 2003; Kumpfer, Alvarado and Whiteside, 2003; Skara and Sussman, 2003; Roe and Becker, 2005; Gates *et al.*, 2009; Stead *et al.*, 2006; Jefferson, Jones & Bellis, 2007; Taylor *et al.*, 2007) that advocate for the implementation of policy measures designed to reduce the rate of alcohol consumption by young people. Prevention strategies at policy level should be focused on enforcing stronger regulation and the inclusion of punishments for any breach regarding these laws.

## **8.7 Conclusions**

The aim of this chapter was to provide a detailed interpretation of the data through the lens of the ecological approach. The discussion drew on the findings generated by the survey, focus-groups, and in-depth interviews carried out with the sample population, and it was structured on the framework of a five-level analysis, namely, at intrapersonal, interpersonal, institutional, community and public policy level.

At an intrapersonal level, the study conducted has shown that the average age at which young people in Community C start drinking is 10 to 11 years old, as early as the primary school years. At this stage, it overlaps with the interpersonal level at which drinking problems may occur as a consequence of bad examples that children have at home, which lead them, subconsciously, to copy that behaviour.

At an institutional level, school students' drinking occurs not only outside, but also inside the school environment, and the young people seem to be very creative in finding ways to source alcohol. Furthermore, the study has revealed that for the youth in Community C, drinking is an enjoyable and socially accepted act. Young people tend to consume alcohol at parties and other social events, very often doing so under the influence of peers (the pressure of peers in alcohol consumption has been broadly discussed above); nevertheless, some youths do engage in drinking with their colleagues while in school.



Considering the data at community level raises a series of equally interesting findings. First and foremost, the community seems to have a very strong impact upon the young people's development, with deep implications in more sensitive issues such as alcohol consumption. The study has shown that almost every element of the community environment can become a source of contribution to the young people's attraction (and access) to alcohol. The discussion has reviewed a series of factors, such as adults' behaviour and their drinking habits, the ease of access young people have to alcohol, as well as the shop owners' role as facilitators and alcohol providers even to the underage.

The discussion of the community factors contributing to the increase in the young people's alcohol consumption rates naturally leads to considerations of the policy implications regarding this matter. From this perspective, action is required both at a local and at a national level in order to mitigate the risks of alcohol misuse across the younger generation.

In summary, examining the data through the lens of the ecological approach has enabled identification of factors that operate at a range of levels which intertwine to contribute significantly to young people's alcohol consumption behaviour.

Examples set by family members at home play a tremendous role in shaping the young people's attitudes and behaviour. Equally influential is the environment outside the home, with the peers' influence contributing significantly to the path chosen by the youth, including choices surrounding alcohol consumption. Furthermore, the community, together with the cultural norms and customs associated with it, contribute to defining the young people's attitude towards drinking, sometimes with implications in the development of government policies.

Nevertheless, irrespective of the causes or the facilitators of alcohol consumption across the younger generation, the study carried out has additionally revealed the consequences that alcohol has, calling for measures in order to mitigate them. As pointed out by the interview participants, alcohol consumption accounts, at least in part, for the increase in the rate of juvenile crime, poor school performance, and all

kinds of accidents, and therefore, action should be taken in order to inform the young people and raise awareness about these consequences.

Besides highlighting the consequences of alcohol consumption, the study has also revealed a series of potential prevention measures and strategies to be used in order to encourage young people not to drink. As posited by the participants in the study, these strategies should be adopted and applied at all levels, starting from the family environment, but also outside it, in schools and public places, at the level of the entire community. In order to be effective, the stakeholders argued that strategies have to be applied collaboratively, in a joint effort, to mitigate the risk of alcohol consumption among the young people.

The findings of my study have been used to develop the model presented in Chapter Nine (Section 9.4, Figure 9.1 Model to show factors associated with young people's alcohol consumption behaviour) which will demonstrate my unique contribution to knowledge from my thesis and the application to practice.

## Chapter 9

### Conclusions, Implications and Recommendations

#### 9.1 Introduction

This final chapter of the thesis follows on from Chapter Eight in which I discussed my findings to answer my research questions:

*‘What are the characteristics of alcohol consumption behaviour of young people in Thailand?’*

*‘What are community stakeholders’ experiences of, and perspectives on, the alcohol consumption behaviour of young people?’*

I will summarise the key conclusions of my study, which will be followed by the presentation of a model (Figure 9.1) developed from my findings which brings together the factors associated with young people’s alcohol consumption behaviour. The model demonstrates the unique contribution to knowledge that my thesis makes and its application to practice. Limitations of the study are also considered. Finally the implications for education and policy are discussed followed by recommendations for the development of an intervention programme and further research.

#### 9.2 Research Question 1

*‘What are the characteristics of alcohol consumption behaviour of young people in Thailand?’*

This study started from the assumption that alcohol consumption among young people is increasing throughout the world, with this segment of the population increasingly running the risk of turning into heavy drinkers in their adulthood. The research has thus far looked into the issue of alcohol consumption among the young people, with a focus on a sample of subjects from the Petchaburi Province in Thailand. This study has tried to find an answer to the research questions. Thus it was revealed that alcohol

consumption among young people started at an early age and that beers and spirits are among the most widely consumed alcoholic products.

The quantitative approach involved collecting data by means of a survey questionnaire distributed to a sample of students aged 15-19 years, who were studying in secondary school. As far as the respondents' family environment was concerned, the survey revealed that the teenagers' relationships with their parents were good, and they lived at home for the most part. The results have shown that a little less than half the respondents had consumed at least one alcoholic beverage, and that boys were more prone to alcohol consumption than girls. Furthermore, drinking alcohol usually occurred over the weekend (Fridays and Saturdays mostly) and in the presence of their friends. As reported by the participants included in the sample, the most commonly met effects of alcohol consumption were feelings of sickness, manifested through nausea and vomiting, or hangovers. Also, the most commonly mentioned reasons for consuming alcohol among the youth were: wanting to try alcohol, pressure from their peers and the drinking habits of their relatives. These findings are similar to the findings of many studies carried out in other countries (Section 2.4-2.6, Chapter Two).

The questionnaires enabled me to collect data about the students' perceptions of their families' attitudes with regards to their alcohol-related habits. The data showed that, although the adolescents had already consumed one or more alcoholic beverages, they did not drink in the presence of their parents. Their families were actually strongly disapproving of such behaviour and prevented their children from drinking at home.

This part of my study generated knowledge that added to what was already known in the field as my study focused on the Petchaburi Province and used a different research tool to gather the quantitative data. The findings therefore build on the previous studies discussed in the literature review (Section 2.6.3, Chapter Two). Within the existing Thai literature, alcohol consumption among young people in Thailand was examined by applying the AUDIT questionnaire (Assanangkornchai *et al.*, 2010; Assanangkornchai *et al.*, 2007) which was primarily designed for identifying levels of problematic drinking. For Assanangkornchai, Mukthong and Intanont (2009), the questionnaire was based on the Core Alcohol and Drug Survey and the Harvard

Alcohol Survey, and the U.S. Youth Risk Behavior Surveillance System. Contrastingly, the SALSUS tool used in my study enabled me to gain a broader and more detailed understanding of young people's drinking related behaviour and the social and structural variables associated with this. Additionally, there was no published research which studied young people's alcohol consumption behaviour in Petchaburi Province.

Although the questionnaire proved to be a very useful tool in drawing a broad picture of alcohol consumption among young people, I felt that it did not provide the in-depth opinions and views that I required for understanding the alcohol consumption behaviour among young people in Thailand. This conclusion called for the development of another approach, in the form of a qualitative study, in order to overcome the limitations of the initial survey. Building on the survey already designed, I conceived a framework based on participatory action research for data collection in the form of focus groups and in-depth interviews in order to reach a deeper understanding of the perceptions of a range of stakeholders to young people's alcohol consumption behaviour.

### **9.3 Research Question 2**

*'What are community stakeholders' experiences of, and perspectives on, the alcohol consumption behaviour of young people?'*

As discussed in Chapter Eight, this study draws on the Ecological Approach developed by McLeroy *et al.* (1988). This approach informed the participatory action research used in the second phase of the study. The qualitative findings of the study revealed a whole new range of data regarding the problem of alcohol consumption among the young people in the Petchaburi Province. It appears that the young people in this community begin to use alcohol at a very young age, as early as their primary school years (at around the age of ten or eleven). Since they are not allowed to do so, they have developed a variety of tactics in order to secretively drink alcoholic beverages at school, or in public places intended for adults (in pubs or in bars). The interviews allowed me to delve deeper into the participants' perceptions, attitudes and behaviours

related to alcohol drinking. Thus, I was able to find out that the teenagers found it pleasurable to drink; they argued that drinking helped them to socialise and bond with their peers. In addition to this, as revealed by the interviews and the focus groups, it appears that young people's drinking is considered to be fashionable. With young people, drinking usually occurs at the houses of those teens who lived on their own, in rented flats, which allowed them to conceal their behaviour from adults. The qualitative data confirmed the survey finding that peer pressure is a factor leading to alcohol consumption, which influenced teens to consume alcohol, sometimes against their will.

It can therefore be inferred that several factors are accountable for the young peoples' drinking habits. Among these, the following were mentioned by the participants in the interviews and the focus groups: family environment and family life and the pressure exerted by peers, colleagues or the society. Alcohol consumption among the young people occurred more in single-parent families compared to those coming from families with both parents present. Another factor revealed as having a tremendous impact on the drinking habits taken up by young people was a social one, which sometimes determined, or enabled young people to consume alcohol. Furthermore, the participants revealed the fact that alcoholic beverages are extremely easy to access since community shops tended to disregard age restrictions to buying alcohol. Another factor considered likely to facilitate alcohol consumption among the youth was the lack of resources available for teaching and awareness-raising in relation to alcohol in schools. In addition, the participants mentioned the lack of consistency between the policies promoted by the government and the Alcohol Act's enforcement across the community. The participants also pointed to the heavy advertising that promotes alcohol, which reaches a wide young audience and influences them into trying alcohol. The young participants in particular stated that alcohol enabled them to relax and to gain confidence in themselves, and it helped them to acquire positive values, considered sophisticated and fashionable. Finally, drinking was considered by a number of the participants as a socially and culturally acceptable activity.

Prevention strategies to control alcohol consumption among young people should start at home, within the family environment, with parents teaching and providing the best

possible example to their children, as well as in schools. Teaching at home is a prevention strategy supported by Buddhist practice which states that children can learn best through examples of good behaviour, especially at young ages, when they tend to reproduce the behaviour they see. Then, teaching at home should be continued in schools, and alcohol consumption should be introduced as a topic in the curriculum. At home as in school, Buddhist practice should be supported as a strategy to prevent young people from drinking.

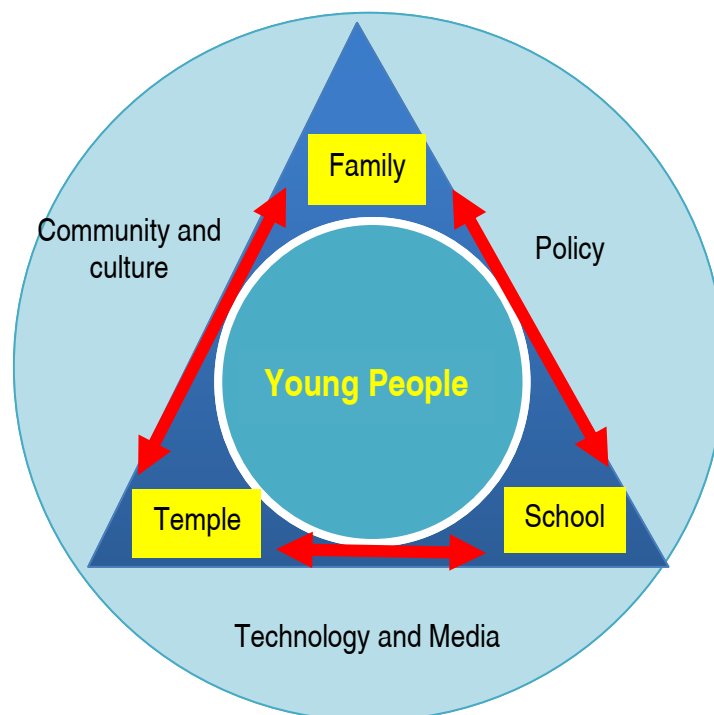
Furthermore, the study revealed the importance of police enforcement as a means of contributing to the prevention of alcohol consumption, by imposing stricter regulations and enforcing them adequately. Action was requested from all participants towards compelling shop owners to stop selling alcohol to young people, which could constitute an effective measure against alcohol consumption. Irrespective of the measure taken, one of the most important aspects revealed by my fieldwork was collaboration. Buddhist practice was the main strategy that all stakeholders raised in my study, and all of them agreed that they should cooperate and gather their efforts together in order to mitigate the risks of alcohol consumption among the younger members of the community.

In this section, the use of participatory action research methods involving stakeholders who represented each social structure in the community in order to gather multi-level points of view led to a new understanding of the link between social structures and external factors influencing young people's drinking in Petchaburi Province. As shown in Chapter Seven, the findings reflected the relation of each social structure, for example, parents referred to the fact that the strategy to prevent young people from consuming alcohol should start with families and then link to teachers at the schools, and people in the community and the policy-makers have to collaborate to control the problem. Moreover, they referred to Buddhists at the temple as the key people to form the good behaviour for young people. Such knowledge builds on the existing evidence base and can be seen in the model of Figure 9.1 in Section 9.4.

## 9.4 Contribution to knowledge

In my study quantitative and qualitative research methods were used to investigate the views of young people and stakeholders' experiences of alcohol consumption behaviour in Petchaburi Province in Thailand. The research approach undertaken in this study provided new insights into how young people access alcohol and the prevention strategies that should be formulated to prevent the problem.

To demonstrate my contribution to new knowledge, I have generated a model using a framework based on the ecological approach (McLeroy *et al.*, 1988). Within my model I have identified the multi-level influences from my study. The model comprises of six main dimensions i.e. family, school, temple, community and culture, policy, and technology and media. The figure below shows the model of multiple factors which are associated with young people's alcohol consumption as discussed through the lens of the ecological approach.



**Figure 9.1 Model to show factors associated with young people's alcohol consumption behaviour**



From Figure 9.1, factors can point out two main factors (Ahlström and Österberg, 2005) that affect young people's alcohol consumption behaviour, namely internal factors and external factors. Internal factors refer to young people's characteristics such as gender, personality factors, and biological traits. Concerning external factors refer to the surrounding environments, social norms or culture, physical availability, and policy.

Drawing from my model (Figure 9.1), I explain the relation between the factors particularly the relation between family, school and temple. In Thai culture most people are Buddhists and they strongly believe in Buddha's teaching. From my study I found that most schools are located near the Buddhist temples, which are at the centre of the community. Thus families, schools and temples have a close relationship. In other words, it is clear that families, schools and temples constitute the main social structures for the Thai people. Families are the places where parents take care of their children and teach them good habits. Then children are sent to schools for studying. Teachers at the schools will have responsibility for the children as the parents do at home. Moreover, they will also teach them by being good role models for their students to copy. This links to Thai culture, in that in the past, parents usually sent their children to study at the Buddhist temples because of the lack of schools in each community. Thai people are also familiar with going to the temple. This becomes an important activity in that Thai people will continue to take their children to temple even though there are enough schools in the community. However, most schools are built near the temples which are the places which set the standards of good behaviour for everyone. Therefore, the relationship between families, schools and temples cannot be separated.

In relation to these three main dimensions, addressing the alcohol consumption of young people has to involve cooperation between all the stakeholders from families, schools and temple. As I discussed in Chapter Eight, parents have a responsibility to look after, teach and be a good role model at home, while the teachers do this in the schools. The Buddhist monks are the people who take action at the temples. In my study all stakeholders believed that Buddhist monks are important people (as well as

parents and teachers) who can teach young people to refrain from consuming alcoholic drinks.

The other dimensions – community and culture, policy, technology and advertising – are external factors which affect young people's consumption of alcoholic beverages and are difficult areas to control. This requires representatives with authority to take action such as community leaders, policy-makers, and the police, as well as the stakeholders in families, schools and temples being aware of the need to encourage young people to know about the negative consequences of alcohol.

As stated above, I will explain each dimension of the model below.

#### **9.4.1 Dimension One: Family**

This dimension concerns the family involved in the alcohol consumption among young people. My study found that family is very important in forming young people's behaviour. It also shows the strength of association between young people's drinking habits and the family concerned.

Consequently, my study shows that alcohol consumption is an imitation behaviour that young people copy from the adults' drinking behaviour, particularly family members. A further finding in my study is the young people's view that they do not need to talk about this issue with their family nor inform them of the negative consequences of alcohol consumption. In contrast, alcohol consumption among young people is not an acceptable habit for parents or guardians. They thought that it was too early for young people to access alcohol at a young age (10-11 years old) and that it is very different from their generation when they started drinking when they reached adulthood and got a job. Moreover, the parent group provided new knowledge to be concerned about the young people's behavioural changes after they used alcohol.

The second key area in this dimension is the changes in family structure and life style. There is a difference between the previous generation and new generation in which children lived with their parents in an extended family which involved many people looking after younger family members. Nowadays, the Thai family structure

comprises many single families where children are sent to a Child Care Centre while their parents work outside the family. This may lead to a lack of time for interaction between family members. In the same way, young people who did not live with both father and mother is a key factor when the pressure or depression can contribute to the reason for young people turning to alcohol.

#### **9.4.2 Dimension Two: School**

My study found that school is another place where young people can access alcohol. Peer pressure from peers in school and peers who left school early were clarified as one important cause of young people's drinking alcohol. Young people start drinking while they are in primary school by the seniors' offering alcohol, or accessing alcohol while they were at alumni parties. Particularly, peers who left school early can be effective in persuading young people to consume alcohol and the students cannot refuse because they are friends, and so must do the same. They will not be accepted as a group member and can be assaulted if they refuse alcohol.

Another key area in this dimension is the school curriculum and the effectiveness of health education at school which students and teachers believe are important matters in controlling alcohol consumption by the youth. The insufficient time allowed for teaching health promotion in school is a reason why young people are not aware of the negative consequences of alcohol consumption.

#### **9.4.3 Dimension Three: Temple**

From my study, this dimension is the only one which is not a cause of young people's alcohol consumption. In contrast, temple is the place that young people are encouraged to refrain from consuming alcohol. All participants in the participatory action research agreed that Buddhist practice at the Buddhist temple will help to control alcohol consumption behaviour. Strategies which participants raised in my study consisted of teaching at the temple, *Dharma* talk, *Tamboon*, *Dharma* camp, ordination, and observing the Five Precepts.

#### 9.4.4 Dimension Four: Community and culture

This dimension consists of the influence of adults' drinking habits, alcohol sales and culture. The misunderstanding of the belief of drinking alcohol after the ancestor worship can lead young people to access alcohol.

From my study, it appears that drinking behaviour is acceptable for Thai men and this seems to be a norm in the community. Furthermore, many activities in Thailand also include drinking alcohol as the main thing to do, for example at the wedding party, ordination ceremony, birthday party, new house celebration, or after work. This activity becomes an example for young people to copy who believe that drinking alcohol is normal and they think that there is no regulation which says that young people cannot drink.

The second key area in this dimension is alcohol sales directed towards young people. Young people are innocently sent by a family member to buy alcohol from the community shop (grocery) for older family members. My study shows that the shop keeper does not ask for the ID card and allows the young people to buy alcohol. Thus young people can obtain alcohol for their own consumption.

Culture is another key area that leads young people to access alcohol. In my study it was recommended (by the participants) that during *Sen Reun*, a ceremony dedicated to Thailand's culture of gratitude, alcohol was used to offer to the 'Ancestor ghost' in this worship, and then young people were allowed to drink that alcohol because they believe it will bring them luck. For the new generation, there is a new cultural phenomenon in Thailand associated with winning, in which alcohol is used in celebrations particularly for the winner of sports competitions. Moreover, young people identified alcohol as the way to become a strong and brave man which made them more creative. Moreover, drinking alcohol after their work was reported to be a pleasurable activity for young people who want to relax.

#### **9.4.5 Dimension Five: Policy**

This dimension directly focuses on the policy makers who do not take serious action to monitor the Alcohol Act, and in order to enforce it the police need more staff. This situation includes the lack of a consistent anti-alcohol campaign in Thailand. Moreover, the sale of alcohol by the community shops to young people who are underage should be a serious concern. As I argue, this insight challenges current policies for controlling the problem of alcohol use among young people which is becoming an urgent issue in need of review.

#### **9.4.6 Dimension Six: Technology and media**

As a result of globalisation, technology rapidly spreads from western countries to Thailand including through the Internet, social media, marketing and advertising. Drinking alcohol among young people appears fashionable to them and it is an acceptable and pleasurable activity as seen in films, TV programmes, and on the Internet. Young people reported the belief that it was smart and attractive to drink alcohol and a ‘Right of Passage’ to adulthood’ (as shown in Section 7.4.8.2).

### **9.5 Implications and Recommendations**

#### **9.5.1 Implications of my findings for the intervention programme**

For my study, the new knowledge provided in this thesis suggests that Buddhist practice is the best strategy which all stakeholders agreed is useful to encourage young people not to consume alcohol. The participants recommended that Buddhist practice should be the way to organize the intervention program for young people to control their drinking from multiple aspects: family, school, and community because Buddhism is interwoven within the Thai community. Thai people respect and pay close attention to practising and following the Buddha’s teachings.

Further findings from my study demonstrate that all stakeholders agreed that cooperation between community members across all the dimensions portrayed in my model is important. The alcohol prevention strategies need to work effectively through

networking between all stakeholders in the community in order to assist each other. The police are the key organisation to take action by strictly and seriously enforcing the law to protect young people against underage drinking supported by community members. Parents will take action at home, teachers will do so in schools while the Buddhist monks will take action in the temples.

### **9.5.2 The proposed intervention programme**

Having identified the main problems which the young people in Petchaburi Province in Thailand are confronting in relation to alcohol consumption behaviour, I propose an intervention programme based on Buddhist practice and taking account of the dimensions in my model (Figure 9.1).

As revealed by both the quantitative and the qualitative studies conducted in this research, Buddhist practice seems to be one possible way to prevent young people from consuming alcohol. This accounts for my choice for religion as a framework for organising the intervention programme designed for the students in School C, Community C, as it may prove useful from a number of perspectives.

Firstly, the participants in the study have acknowledged the importance of Buddhist practice holding up as an example the Buddhist way which encourages virtuous behaviour and refraining from alcohol abuse, which is considered to be a sin. The fifth precept of the Buddhist religion advocates the avoidance of alcohol. Secondly, as revealed by the focus groups, the family can rely on Buddhist practice in order to teach their children about the negative effects of alcohol, encouraging them not to drink alcoholic beverages. According to Buddhist practice, the best way in which the family can do so, is by personal example. Thirdly, the participants in the interviews and the focus groups agreed upon the fact that Buddhist practice can serve as a model upon which activities can be built in schools (one such example mentioned was *Dharma* camp), in order to help students to resist the temptation of consuming alcohol, advocating the need to request assistance from a monk, who was considered as more experienced and more resourceful in advising students not to resort to alcohol. Fourthly, Buddhist practice at the temple was deemed by the participants as the main

source of teaching about Buddhism, and, given its authority, it was suggested as a possible location for organising activities for the young people (such as the ‘Sunday *Dharma* School’) in order to help them refrain from alcohol. Finally, the observance of the five precepts was mentioned as a possible alternative for convincing students that alcohol is harmful for their health.

Taking into account the above considerations, I argue that the Buddhist religion is closely connected to the life of the Thai community. As pointed out in the focus groups and in the interviews, the people in Community C seem to respect and follow Buddhist religious teachings. The members of this community strongly believe that Buddhist practice is of the utmost importance in assisting their children to refrain from drinking alcoholic beverages. This accounts once again for my decision to develop an intervention programme in cooperation with stakeholders based on the Buddhist practice to be implemented in School C.

The assessment of such an intervention programme would need to be carried out and could be done by means of another quantitative and qualitative study, in the form of survey questionnaires and in-depth interviews conducted at the end of the programme. This could provide an indication of the programme’s usefulness and its applicability in reducing the rate of alcohol consumption among the students.

### **9.5.3 Implications for research**

#### **9.5.3.1 Further research with the wider student population in Petchaburi Province and other regions in Thailand**

In order to confirm the transferability of the findings of this study, further research could be conducted and expanded to the total population of students in Petchaburi Province as well as to other regions of the country. This would be useful in confirming my findings on the relationship of alcohol consumption and the younger generation. Furthermore, instead of a mere replication of the study on a different population, action should be directed towards gaining more insights and a better understanding of the way in which the adolescents interpret the Buddhist views of alcohol, in particular by

carrying out focus groups and interviews centred on the issue of the impact of Buddhism on alcohol consumption. Such an endeavour might result in the uncovering of a whole range of connections between Buddhism and alcohol prevention, as well as on the students' understanding of religion, and what they deem as good religious practice. Further research in this direction would certainly fill a gap, given the importance that religions play in all cultures, and considering their possible impact on people's health. This is a field that requires further exploration.

#### **9.5.3.2 Further multi-dimensional research**

This study has approached young people's alcohol-related behaviour from the perspective of a five-level framework based on the ecological approach (Section 8.2 – 8.6, Chapter Eight), namely the intrapersonal, the interpersonal, the institutional, the community and policy levels. While the focus of my research has been predominantly on the first three levels mentioned above, further research could be directed towards exploring in more detail the impact that the community leaders and the policy-makers are likely to have on the development of the young people, as far as their alcohol-related behaviour is concerned.

Studies could be conducted to explore in more detail those aspects related to community involvement and to find new ways to prevent young people from accessing alcohol, or, at least, to make sure that the adolescents who already consume alcohol are aware of the dangers involved and act responsibly. With the help of policies designed to promote the health and wellbeing of the young people affected by drinking, the community can find new ways to mitigate the risk of alcohol consumption.

#### **9.5.4 Implications for education**

As discussed in Chapter Eight, my study found that there was insufficient information available to young people regarding alcohol use and the negative impact which its consumption was likely to have on their development. Participants agreed that one hour a week seemed insufficient for classes on health promotion. The results from my



study should encourage school principals to think about modifying the school curriculum in order to increase the time spent on health promotion in schools. Advisory teachers and other teaching staff were particularly concerned about the negative impact of young people's participation in alcohol consumption which suggests that it is the responsibility of all teachers to promote the students' health. This includes teachers being aware of their own habits to provide a good role model for students to imitate. In order to ensure the effectiveness of these measures, teachers could cooperate with parents to support them to look after their young people at home while teachers would take action at school. One thing that is very important is sharing information between parents and teachers. Parents could provide information about alcohol consumption behaviour among young people at home to assist teachers to design classes to promote the avoidance of alcohol.

#### **9.5.5 Implications for policy**

One finding of my study is that the police do not usually take action that is consistent with the control of alcohol sale and consumption. Furthermore the policy-makers never check that the policies are being carried out. My research has identified a lack of staff to monitor whether the Alcohol Act in Thailand is complied with in the community, particularly with regard to selling alcohol to the underaged, even though this policy should be effective in reducing alcohol consumption among young people. The findings of my study should help to encourage the policy-makers and the police to be consistent in monitoring the enforcement of the Alcohol Act, particularly with regard to the control of alcohol sales by community shops and the Minimum Legal Drinking Age (MLDA) – which is 20 years old.

Following the same line of argument, I consider that effective measures can be taken to reduce alcohol consumption by promoting anti-alcohol campaigns. Moreover, alcohol advertisements should be banned. This includes the advertising in print and broadcast media, billboards, the Internet, direct mail, and product placement. Moreover, it also includes bans on promotions, free gifts, coupons and sponsorships which all aim to promote alcohol products. However, this would not be easy without lobbying consumer groups such as retailers.

## **9.6 Limitation of my study**

As stated in Chapter Three, my study was designed following action research which would have taken too much time in undertaking all the cycles: i.e. 1) address or diagnose community problems, 2) action planning, 3) taking action, 4) evaluation, and 5) identifying general findings. For my PhD programme I was working within a timeframe of three years which did not allow me enough time to undertake the whole cycle.

In this case, my supervisors and I have discussed my concerns. Finally, I decided to carry out the first step (address or diagnose community problems) and step two, action planning in order to recommend the intervention programme for the third step (taking action). For data collection, I chose to study the samples in Petchaburi Province particularly in Community C which is only a part of the total population of young people in this province, and I have made recommendations to apply my methodology to undertake further research with the total population in Petchaburi Province and transfer it to the other provinces nationwide (see Section 9.5.3.1).

It is my responsibility as a researcher to ensure that this study will not stop with my PhD programme. I have planned to continue to carry out further research in the future. I will modify the intervention programme as posited in Section 9.5.1, and then I will take action with the stakeholders in the community. The evaluation will follow the action plan. Finally, I have defined new knowledge from my study in order to look back on the community problem of alcohol consumption. The problem will be assessed and the evidence from each cycle will be used to re-assess the problem in the

subsequent cycle by introducing similar or alternative strategies until the problem is resolved.

## **9.7 Conclusions**

This chapter proposes a model based on Buddhist practice designed to contribute to raising the awareness of young people in relation to the dangers associated with alcohol consumption, especially at a young age. It also aims to enable practitioners, policy makers and a range of stakeholders to prevent alcohol consumption in young people.

In order to move in this direction, I started by providing a summary of the research carried out in this thesis, which accounts for any further steps to be taken at a later date. Hence, by reviewing the data gathered by means of both quantitative and qualitative methods, I advocate for an intervention programme to be implemented in School C, in Community C Petchaburi Province, Thailand as the first step to designing a national intervention programme.

However, in order to reach the best possible results, any action taken should be based on collaboration and cooperation with all stakeholders involved, from the students themselves, to their parents, peers, the school and healthcare staff, and the wider community. This accounts for the need for further research directed towards the lesser-explored dimensions of my model involved in children's development and alcohol-related behaviours. Nevertheless, any actions taken at institutional or community level have to be supported by governmental initiatives. The existing policies should be enforced and directed towards the protection of those at risk, or if necessary, other regulations should be designed and implemented.

## References

- Adalbjarnardottir, S., & Hafsteinsson, L. G. (2001). Adolescents' perceived parenting styles and their substance abuse: Concurrent and longitudinal analyses. *Journal of Research on Adolescence*, 11(4), 401-423.
- Advisory Council on the Misuse of Drugs. (2006). *Pathways to Problems; Hazardous use of tobacco, alcohol and other drugs by young people in the UK and its implications for policy*. London: Home Office.
- Ahlström, S. K., & Österberg, E. L. (2005). International Perspectives on Adolescent and young Adults Drinking. *Alcohol Research & Health*, 28(4), 258-268.
- Ahlström, S. K., Bloomfield, K., & Knibbe, R. (2001). Gender differences in drinking patterns in nine European countries: Descriptive findings. *Substance Abuse*, 22(1), 69-85.
- Alcohol Beverage Control Act. (2008). *Alcohol Beverage Control Act B.E. 2551 (2008)*. Retrieved from <http://www.thailawforum.com/laws/Alcoholic%202551.pdf> Accessed 23<sup>rd</sup> May 2013.
- Allamani, A. (2008). Alcoholic Beverages, Gender and European Cultures. *Substance use & misuse*, 43(8-9), 1088-1097.
- Allen, E., & Marotz, L. (2003). *Developmental Profiles Pre-Birth through Twelve* (4<sup>th</sup> ed). Albany, NY: Thomson Delmar Learning.
- American Nurses Association (ANA). (2010). *Code of Ethics for Nurses*. Retrieved from <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.pdf> Accessed 11<sup>th</sup> November 2014.
- Anderson, P., Brujin, A., Angus, K., Gordon, R., & Hastings, G. (2009). Impact of Alcohol Advertising and Media Exposure on Adolescent Alcohol Use: A Systematic Review of Longitudinal Studies. *Alcohol and Alcoholism*, 44 (3), 229-243.
- Anderson, P., Möller, L., & Galea, G. (2012). *Alcohol in the European Union: Consumption, harm and policy approaches*. Retrieved from <http://www>.

euro.who.int/\_data/assets/pdf\_file/0003/160680/e96457.pdf Accessed 12<sup>th</sup> July 2013.

- Andrews, J. A., Hops, H., Ary, D., Tidesley, E., & Harris, J. (1993). Parental influence on early adolescent substance use: Specific and non-specific effects. *Journal of early adolescence*, 13 (3), 285-310.
- Araos C., Cea M., Ferna'ndez M., & Valenzuela, E. (2014). The Role of School Context on Marijuana Use in Chile: A Classroom-Level Analysis. *Deviant Behavior*, 35, 412–432.
- Ary, D. V., Duncan, T. E., Biglan, A., Metzler, C. W., Noell, J. W., & Smolkowski, K. (1999). Development of adolescent problem behavior. *Journal of Abnormal Child Psychology*, 27, 141–150.
- Assanangkornchai, S. (2006). Epidemiology and intervention strategies for underage drinking in Thailand and other Southeast Asian countries. *Alcoholism-Clinical and Experimental Research*, 30(9), 116A-116A.
- Assanangkornchai, S., Geater, A. F., Saunders, J. B., & McNeil, D. R. (2002). Effects of paternal drinking, conduct disorder and childhood home environment on the development of alcohol use disorders in a Thai population. *Addiction*, 97(2), 217-226.
- Assanangkornchai, S., Mukthong, A., & Intanont, T. (2009). Prevalence and Patterns of Alcohol Consumption and Health-Risk Behaviours among High School Students in Thailand. *Alcoholism: Clinical and Experimental Research*, 33(12), 2037-2046.
- Assanangkornchai, S., Pattanasattayawong, U., Samangsri, N., & Mukthong, A. (2007). Substance use among high-school students in Southern Thailand: Trends over 3 years (2002-2004). *Drug and Alcohol Dependence*, 86(2-3), 167-174.
- Assanangkornchai, S., Sam-Angsri, N., Rerngpongpan, S., & Lertnakorn, A. (2010). Patterns of Alcohol Consumption in the Thai Population: Results of the

National Household Survey of 2007. *Alcohol and Alcoholism*, 45(3), 278-285.

ASTV manager online. (2013). *No Alcohol in the Buddhist Lent.*, Retrieved from <http://www.manager.co.th/qol/viewnews.aspx?NewsID=9560000089912> (in Thai) Accessed 9<sup>th</sup> April 2014.

Babor, T. F., Higgins-Biddle, J. C., Saunders, J. B., & Monteiro, M. G. (2001). *The Alcohol Use Disorders Identification Test (AUDIT)*. Retrieved from [http://whqlibdoc.who.int/hq/2001/who\\_msd\\_msb\\_01.6a.pdf](http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf) Accessed 8<sup>th</sup> January 2012.

Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., ... Rossow, I. (2003). *Alcohol: No Ordinary Commodity: Research and Public Policy*. Oxford: Oxford University Press.

Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A. (2001). Social cognitive theory: An agentic perspective. *Annual Review of Psychology*, 52, 1-26.

Bandura, A., & Walters, R. H. (1963). *Social learning and personality development*. New York: Holt, Rinehart & Winston.

Barbour, R. S., & Kitzinger, J. (1999). *Developing Focus Group Research: Politics, Theory and Practice*. London: SAGE Publications.

Battaglia, M. P. (2008). *Encyclopedia of Survey Research Methods*. Retrieved from <http://srmo.sagepub.com/view/encyclopedia-of-survey-research-methods/n311.xml> Accessed 25<sup>th</sup> May 2013.

Bauman, K. E., Foshee, V. A., Ennett, S. T., Hicks, K., & Pemberton, M. (2001). Family matters: A family-directed program designed to prevent adolescent tobacco and alcohol use. *Health Promotion Practice*, 2(1), 81–96.

BBC News. (2009). *Buddhism at a glance*. Retrieved from <http://www.bbc.co.uk/religion/religions/buddhism/ata glance/glance.shtml> Accessed 26<sup>th</sup> March 2014.

- Bee, H., & Boyd, D. (2014). *The Developing Child*. (13th ed.) Essex: Pearson Education.
- Belsky, J. (1980). Child Maltreatment: An Ecological Integration. *American Psychologist*, 35(4), 320-335.
- Bennett, L. A., Campillo, C., Chandrashekar, C. R., & Gureje, O. (1998). Alcoholic beverage consumption in India, Mexico, and Nigeria: a cross-cultural comparison. *Alcohol Health & Research World*, 22(4), 243-252.
- Bergmark, K. H., & Kuendig, H. (2008). Pleasures of drinking: a cross-cultural perspective. *Journal of Ethnicity Substance abuse*, 7(2), 131-153.
- Berk, E. L. (2010). *Infants, Children, and Adolescents* (7th ed.). Upper Saddle River, NJ: Pearson Education.
- Berk, E. L. (2013). *Child development* (9th ed). Upper Saddle River, NJ: Pearson Education.
- Berridge, G. R. (2005). *Diplomacy: Theory and Practice* (3rd ed). New York: Palgrave Macmillan.
- Beuret, K., Corbett, B. & Ward, H. (2012). *Drinking among British women and its impact on their pedestrian and driving activities: A review of the literature*. Retrieved from <http://www.reesjeffreys.co.uk/wp-content/uploads/2010/10/Women-and-Drinking-Literature-Review-2012.pdf> Accessed 21 July 2015.
- Biglan, A., Ary, D. V., Smolkowski, K., Duncan, T. & Black, C. (2000). A randomized controlled trial of a community intervention to prevent adolescent tobacco use. *Tobacco Control*, 9(1), 24–32.
- Black, C., Eunson, J., Sewel, K., & Murray, L. (2010). *Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) National Report Smoking, Drinking and Drug use among 13 and 15 year olds in Scotland in 2010*. Retrieved from [http://www.drugmisuse.isdscotland.org/publications/local/SALSUS\\_2010.pdf](http://www.drugmisuse.isdscotland.org/publications/local/SALSUS_2010.pdf) Accessed 21 August 2013.

- Black, C., MacLardie, J., Maihot, J., Murray, L., & Sewel, K. (2008). *Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) National Report Smoking, Drinking and Drug use among 13 and 15 year olds in Scotland in 2008*. Retrieved from [http://www.esds.ac.uk/doc/7374/mrdoc/pdf/7374\\_salsus\\_2008\\_technical\\_report.pdf](http://www.esds.ac.uk/doc/7374/mrdoc/pdf/7374_salsus_2008_technical_report.pdf) Accessed 8<sup>th</sup> June 2011.
- Blakemore, S., Burnett, S., & Dahl, R. (2010). The role of puberty in the developing adolescent brain. *Human Brain Mapping*, 31, 926-33.
- Bloor, M., Thomas, M., Robson, K., & Frankland, J. (2001). *Focus Groups in Social Research*. London: SAGE Publications.
- Boesch, E. (1977). Authority and work attitude of Thais. In K. Wenk & K. Rosenberg (Eds.), *Thai in German eyes* (pp. 176-231). Bangkok: Thailand.
- Boocock, S. S. (1991). Childhood and children in Japan and the United States: A comparative analysis. In *Sociological studies of child development*, Vol. 4: Perspective on and of children (pp. 51-88). Greenwich, CT: JAI Press.
- Bovornkitti, L. (2005). Spirituality in Art: Buddhist Values in Thailand. *The Journal of the Royal Institute of Thailand*, 30(3), 732–741.
- Boyce, C., & Neale, P. (2006). *Conducting In-depth Interviews: A Guide for Designing and Conducting In-Depth Interviews for Evaluation Input*. *Pathfinder International Tool Series*. Retrieved from [http://www2.pathfinder.org/site/DocServer/m\\_e\\_tool\\_series\\_indepth\\_interviews.pdf](http://www2.pathfinder.org/site/DocServer/m_e_tool_series_indepth_interviews.pdf) Accessed 18<sup>th</sup> August 2011.
- Bronfenbrenner, U. (1979). *The Ecology of Human Development*. Cambridge: Harvard University Press.
- Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology*, 22(6), 723–742.
- Brown, S. A., McGue, M., Maggs, J., Schulenberg, J., Hingson, R., Swartzwelder, S., Martin, C., Chung, T., Tapert, S. F., Sher, S., & Winters, K. C. (2008). A



Developmental Perspective on Alcohol and Youths 16 to 20 Years of Age.  
*PEDIATRICS*, 121(Supplement 4), s290-310.

Buddhist Studies. (2013). *Basic Buddhism Guide*. Retrieved from <http://www.buddhanet.net/e-learning/index.htm> Accessed 18<sup>th</sup> July 2013.

Burawoy, M. (1991). *Ethnography Unbound: Power and Resistance in the Modern Metropolis*. CA: University of California Press.

Burawoy, M. (2009). *The Extended Case Method: Four Countries, Four Decades, Four Great Transformations, and One Theoretical Tradition*. CA: University of California Press.

Burns, R., & Burns, R. (2008). *Business Research Methods and Statistics Using SPSS*. London: SAGE Publications.

Burris, J. L., Sauer, S. E., & Carlson, C. R. (2011). A test of religious commitment and spiritual transcendence as independent predictors of underage alcohol use and alcohol-related problems. *Psychology of Religion and Spirituality*, 3(3), 231.

Cairns, R. B., & Cairns, B. D. (2006). The Making of Developmental Psychology. In R. M. Lerner (Ed.). *Theoretical models of human development. Volume 1 of Handbook of Child Psychology (6th ed.)* Editors-in-chief: W. Damon & R. M. Lerner. Hoboken, NJ: John Wiley & Sons.

Carlson, N., & Buskist, W. (1997). *Psychology; The science of behaviour*. Boston: Allyn and Bacon.

Casey, B. J., Jone, R. M., Levita, L., Libby, V., Pattwell, S., Ruberry, E., Soliman, F., & Somerville, L. H. (2010). The storm and stress of adolescence: insights from human imaging and mouse genetics. *Developmental Psychobiology*, 52(3), 225-235.

Center for Substance Abuse Prevention. (2000). *The national cross-site evaluation of high risk youth programs: Final report*. Rockville, MD: Center for Substance

Abuse Prevention, Substance Abuse and Mental Health Services Administration.

Centre for Alcohol Studies (CAS). (2007). *Status of alcohol consumption*. Bangkok: Office of Narcotics Control Board. (in Thai)

Chamratrithirong, A., Miller, B. A., Byrnes, H. F., Rhucharoenpornpanich, O., Cupp, P. K., Rosati, M. J., Fongkaew, W., Atwood, K. A., & Chookhare, W. (2010). Spirituality within the family and the prevention of health risk behavior among adolescents in Bangkok, Thailand. *Social science & medicine*, 71(10), 1855-1863.

Chao, R., & Tseng, V. (2002). Parenting of Asians. In *Handbook of parenting*, Vol. 4: Social conditions and applied parenting (2nd ed.) (pp. 59-93) Mahwah, N. J.: Lawrence Association Publishers.

Chartier, K. G., Hesselbrock, M. N., & Hesselbrock, V. M. (2011). Alcohol problems in young adults transitioning from adolescence to adulthood: The association with race and gender. *Addictive Behaviors*, 36(3), 167–174.

Chatterton, P., Fuller, D., & Routledge, P. (2007). Relating action to activism: Theoretical and methodological reflections. In S. Kindon, R. Pain, & Kesby, M. (2007). *Participatory action research approaches and methods: connecting people, participation and place*. Routledge studies in human geography, 22. London: Routledge.

Chaveepojnkamjorn, W., & Pichainarong, N. (2007). Factors associated with alcohol consumption among upper secondary school students. *Southeast Asian Journal of Tropical Medicine and Public Health*, 38(1), 146-151.

Choudhury, S., Blakemore, S., & Charman, T. (2006). Social cognitive development during adolescence. *Social Cognitive Affect Neuroscience*, 1(3), 165-174.

Cismaru, M., Deshpande, S., Thurmeier, R., Lavack, A., & Agrey, N. (2010). Preventing fetal alcohol spectrum disorders: the role of protection motivation theory. *Health Marketing Quarterly*, 27(1), 66-85.

- Cochrane, R., & Bal, S. (1990). The drinking habits of Sikh, Hindu, Moslem and white men in the West Midlands: a community survey. *British Journal of Addiction*, 85, 759–769.
- Cole, M., Cole, S. R., & Lightfoot, C. (2005). *The development of children* (5th ed.). New York: Worth Publishers.
- Coleman, J. C., & Hendry, L. B. (1999). *The Nature of Adolescence*. London: Routledge.
- Committee on Developing a Strategy to Reduce and Prevent Underage Drinking, Youth, and Families Board on Children, National Research Council, and National Academy of Sciences. (2004). *Reducing Underage Drinking: A Collective Responsibility*. Washington: National Academies Press.
- Coughlan, P., & Coughlan, D. (2002). Action research for operations management. *International Journal of Operations & Production Management*, 22(2), 220-240.
- Cox, W. M., & Klinger, E. (1988). A motivational model of alcohol use. *Journal of Abnormal Psychology*, 97(2), 168-180.
- Crain, W. (2005). *Theories of development* (5th ed.). Upper Saddle River, NJ: Prentice-Hall.
- Crain, W. (2011). *Theories of Development: Concepts and Applications* (6th ed.). Upper Saddle River, NJ: Pearson Education.
- Cromer, B. (2011). Adolescent Development. In Kliegman R.M., Behrman, R.E., Jenson, H.B., Stanton, B.F. (Eds.), *Nelson Textbook of Pediatrics*. (19th ed.) (pp. 649–659). Philadelphia, PA: Saunders Elsevier.
- Cronholm, S., & Goldkuhl, G. (2003). *Understanding the practices of action research*. Accepted to the 2nd European Conference on Research Methods in Business and Management (ECRM 2003), Reading, UK, 20-21 March, 2003. Retrieved from <http://www.vits.org/publikationer/dokument/339.pdf> Accessed 18<sup>th</sup> May 2012.

- Cuijpers, P. (2005). Prevention programmes for children of problem drinkers: a review. *Drugs: Education, Prevention and Policy*, 12(6), 465–475.
- Cuijpers, P., (2003). Three decades of drug prevention research. *Drugs: Education, Prevention and Policy*, 10(1), 7–20.
- Cuijpers, P., Jonkers, R., de Weerd, I., & de Jong, A. (2002). The effects of drug abuse prevention at school: the Healthy School and Drugs project. *Addiction*, 97(1), 67–73.
- Currie, C., Gabhainn, S. N., Godeau, E., Robert, C., Smith, R., & Currie, D. (Eds.). (2008). *Inequalities in young people's health: Health Behaviour in School-aged Children. International report from the 2005/2006 survey*. Retrieved from [http://www.euro.who.int/data/assets/pdf\\_file/0005/53852/E91416.pdf](http://www.euro.who.int/data/assets/pdf_file/0005/53852/E91416.pdf) Accessed 12<sup>th</sup> August 2011.
- Dahl, R. (2004). Adolescent brain development: a period of vulnerabilities and opportunities. Keynote address. *Annals New York Academy Sciences*, 1021, 1-22.
- Dahlke, P., Sīlācāra, B., Oates, L. R., & Lounsbery, G. C. (2008). *The Five Precepts*. Retrieved from <http://www.bps.lk/olib/wh/wh055-u.html> Accessed 26<sup>th</sup> March 2014.
- Department of Health and Human service. (2010). *Heavy Episodic Consumption of Alcohol*. Retrieved from [http://www.lsmsa.edu/files/WOW\\_Binge\\_Drinking\\_Display\\_Signs.pdf](http://www.lsmsa.edu/files/WOW_Binge_Drinking_Display_Signs.pdf) Accessed 16<sup>th</sup> March 2011.
- Department of Policy. (2012). *School Size*. Retrieved from [http://plan.sesao1.go.th/school\\_size.php](http://plan.sesao1.go.th/school_size.php) (in Thai) Accessed 24<sup>th</sup> March 2012.
- Diment, E., Harris, H., Jotangia, D., Lee, L., McManus, S., Ogunbadejo, T., Pickup, D., & Thompson, J. (2009). *Smoking, drinking and drug use among young people in England in 2008*. London: The NHS Information Centre for Health and Social Care.

- Dishion, T., & Kavanagh, K. (2000). A multilevel approach to family-centered prevention in schools: process and outcome. *Addictive Behaviors*, 25(6), 899–911.
- Dishion, T., & Kavanagh, K. (2003). *Intervening in Adolescent Problem Behavior*. Oregon: Guilford Press.
- Dodds, I. G., Bainbridge, R., Wood, L., & Robb, S. (2014). *Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) National Report Alcohol use among 13 and 15 year olds in Scotland 2013*. Edinburgh: National Health Service Scotland. Retrieve from [http://www.isdscotland.org/Health-Topics/Public-Health/Publications/2014-11-5/SALSUS\\_2013\\_Alcohol\\_Report.pdf](http://www.isdscotland.org/Health-Topics/Public-Health/Publications/2014-11-5/SALSUS_2013_Alcohol_Report.pdf) Accessed 9<sup>th</sup> February 2015.
- Donaldson, L. (2009). *Guidance on the Consumption of Alcohol by Children and Young People*. London: Department of Health.
- Donovan, J. E. (2004). Adolescent alcohol initiation: a review of psychosocial risk Factors. *Journal of Adolescent Health*, 35(6), 529.e7–529.e18.
- Doody, O., Slevin, E. & Taggart, L., (2013). Preparing for and conducting focus group interviews in nursing research: part 2. *British Journal of Nursing*, 22(3), 170-173.
- Doody, O., Slevin, E., & Taggart, L. (2013). Focus group interviews in nursing research: part 1. *British Journal of Nursing*, 22(1), 16-19.
- Doody, O., Slevin, E., & Taggart, L. (2013). Focus group interviews part 3: Analysis. *British Journal of Nursing*, 22(5), 266-269.
- Eklund J. M., & Klinteberg, B. (2005). Personality characteristics as risk indications of alcohol use and violent behaviour in male and female adolescents. *Journal of Individual Differences*, 26, 63–73.
- Eklund, J. M., & Klinteberg, B. (2009). Alcohol Use and Patterns of Delinquent Behaviour in Male and Female Adolescents. *Alcohol & Alcoholism*, 44(6), 607-614.

- Ellickson, P., Collins, R., Hambarsoomians, K., & McCaffrey, D. (2005). Does alcohol advertising promote adolescent drinking? Results from a longitudinal assessment. *Addiction*, 100(2), 235–46.
- Endler, N. S., & Magnusson, D. (1976). Personality and Person by Situation Interactions. In Endler, N. S., & Magnusson, D. (Eds.), *Interactional Psychology and Personality*, 1-26. New York: John Wiley and Sons.
- Field, A. (2000). *Discovering Statistics Using SPSS for Windows: Advanced Techniques for Beginners (Introducing Statistical Methods series)*. London: SAGE Publications.
- Fletcher A., Bonell C., Sorhaindo, A., & Strange, V. (2009). How might schools influence young people's drug use? Development of theory from qualitative case- study research. *Journal Adolescent Health*, 45(2), 126–132.
- Fletcher, A., Bonell, C., & Hargreaves, J. (2008). School effects on young people's drug use: a systematic review of intervention and observational studies. *Journal of Adolescent Health*, 42(3), 209–220.
- Foxcroft, D. R., Ireland, D., Lister-Sharp, D.J, Lowe, G., & Breen, R. (2003). Longer-term primary prevention for alcohol misuse in young people: a systematic review. *Addiction*, 98(4), 397–411.
- Francis, L. J., (1997). The impact of personality and religion on attitude towards substance use among 13- 15 year olds. *Drug and Alcohol Dependence*, 44, 95- 103.
- French, M. T., & Maclean, J. C. (2006). Underage alcohol use, delinquency, and criminal activity. *Health Economics*, 15, 1261–1281.
- Fuller, E., & Hawkins, V. (2014). *Smoking, Drinking and drug use among young people in England 2013*. London: Health and Social Care Information Centre.

- Gates, S., McCambridge, J., Smith, L., & Foxcroft, D. (2009). *Interventions for prevention of drug use by young people delivered in non-school settings*. Coventry: John Wiley & Sons, Ltd.
- Gesell, A. (1933). Maturation and patterning of behavior. In C. Murchison (Ed.), *A handbook of child psychology*. Worcester, MA: Clark University Press.
- Gill, J. S. (2002). Reported levels of alcohol consumption and binge drinking within the UK undergraduate student population over the last 25 years. *Alcohol and Alcoholism*, 37, 109-120.
- Gill, V., Hawkins, V., Mandalia, D., & Whalley, R. (2012). *Smoking, drinking and drug use among young people in England in 2011*. London: Health and Social Care Information Centre.
- Glanz, K., Rimer, B. K., & Lewis, F. M. (2002). *Health Behavior and Health Education. Theory, Research and Practice*. San Francisco: John Wiley & Sons.
- Glasow, P.A. (2005). Fundamentals of Survey Research Methodology. Retrieved from <http://www.uky.edu/~kdbad2/EPE619/Handouts/SurveyResearchReading>. Pdf Accessed 25th May 2012.
- Gogtay, N., Giedd, J., Lusk, L., Hayashi, K., Greenstein, D., Vaituzis, A., ... Thompson, P. (2004). Dynamic mapping of human cortical development during childhood through early adulthood. *Proceedings of the National Academy of Sciences (PNAS)*, 101(21), 8174-8179.
- Goswami, U. (2008). *Cognitive Development: The Learning Brain*. Hove: Psychology Press.
- Greasley, P. (2008). *Quantitative data analysis using SPSS – an introduction for health and social science*. Berkshire, England: Open University Press.
- Green, L. W., & Kreuter, M. W. (2005). *Health Program Planning: An Educational and Ecological Approach*. New York: McGraw-Hill.

- Green, L.W., George, M. A., Daniel, M., Frankish, C. J., Herbert, C. P., Bowie, W. R. & O'Neill, M. (2003). Appendix C: Guidelines for Participatory Research in Health Promotion. In Meredith, M., & Wallerstein, N. (Eds.), *Community-Based Participatory Research for Health*. San Francisco, CA: Jossey-Bass.
- Gregg, J., & O'Hara, L. (2007). The Red Lotus Health Promotion Model: a new model for holistic, ecological, salutogenic health promotion practice. *Health Promotion Journal of Australia*, 18(1), 12-19.
- Grube J. W., & Waiters, E. (2005). Alcohol in the media: content and effects on drinking beliefs and behaviors among youth. *Adolescent Medicine Clinics*, 16(2), 327-343.
- Grudens-Schuck, N., Lundy-Allen, B. L., & Larson, K. (2004). *Focus Group Fundamentals*. Ames, Iowa: Iowa State University Extension.
- Guilamo-Ramos, V., Jaccard, J., Turrissi, R., & Johansson, M. (2005). Parental and School Correlates of Binge Drinking Among Middle School Students. *American Journal of Public Health*, 95(5), 894-899.
- Gunning, N., Jotangia, D., Nicholson, S., Ogunbadejo, T., Reilly, N., Simmonds, N., & Wardle, H. (2010). *Smoking, drinking and drug use among young people in England in 2009*. London: The NHS Information Centre for Health and Social Care.
- Hallfors, D., Cho, H., Brodish, P. H., Flewelling, R., & Khatapoush, S. (2006). Identifying high school students "at risk" for substance use and other behavioral problems: implications for prevention. *Substance Use and Misuse*, 41, 1-15.
- Hansen, W. B., Johnson, C. A., Flay, B. R., Phil, D., Graham, J. W., & Sobel, J. (1988). Affective and Social Influences Approaches to the Prevention of Multiple Substance Abuse among Seventh Grade Students: Results from Project SMART. *Preventive Medicine*, 17, 135-154.



- Harrington, V. (2000). *Underage drinking: Findings from the 1998–1999 Youth Lifestyles Survey*. London: Home Office Research, Development and Statistics Directorate.
- Harrop, E., Addis, S., Elliott, E., & Williams, G. (2006). *Resilience, coping and salutogenic approaches to maintaining and generating health: A review*. Cardiff: Cardiff Institute of Society, Health and Ethics.
- Hart, E., & Bond, M. (1995). *Action Research for Health and Social Care: a guide to practice*. Buckingham: Open University Press.
- Health and Social Care Information Centre. (2011). *Statistics on Alcohol: England 2011*. Retrieved from <http://www.hscic.gov.uk/pubs/alcohol11> Accessed 23<sup>rd</sup> November 2013.
- Health and Social Care Information Centre. (2012). *Statistics on Alcohol: England 2012*. Retrieved from <http://www.hscic.gov.uk/catalogue/PUB06166/alco-eng-2012-rep.pdf> Accessed 23<sup>rd</sup> November 2013.
- Health and Social Care Information Centre. (2013). *Statistics on Alcohol: England 2013*. Retrieved from <http://www.hscic.gov.uk/catalogue/PUB10932/alco-eng-2013-rep.pdf> Accessed 23<sup>rd</sup> November 2013.
- Heath, D. B. (2001). Culture and substance abuse. *Psychiatry Clinical North American*, 24: 479-96.
- Henderson, H., Nass, L., Payne, C., Phelps, A., & Ryley, A. (2013). *Smoking, drinking and drug use among young people in England in 2012*. London: Health and Social Care Information Centre.
- Hibell, B., Andersson, B., Bjarnason, T., Ahlström, S., Balakireva, O., & Kokkevi, A. (2004). *The ESPAD Report: Alcohol and Other Drug Use Among Students in 35 European Countries*. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs.
- Hibell, B., Guttormsson, U., Ahlström, S., Balakireva, O., Bjarnason, T., Kokkevi, A., & Kraus, L. (2009). *The 2007 ESPAD Report: Substance Use Among*

- Students in 35 European Countries*. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs.
- Hochschild, A. R. (1983). *The Managed Heart*. Los Angeles, CA: University of California Press.
- Hornik, R., Jacobson, L. Orwin, R., Piesse, A., & Kalton, G. (2008). Effects of the National Youth Anti-Drug Media Campaign on Youths. *American Journal of Public Health*, 98, 2229-2236.
- Hutchison, S., & Wilson, H. (1994). *Research and Therapeutic interviews in Morse 1994. Critical Issues in Qualitative research methods*. London: SAGE Publications.
- Institute of Alcohol Study. (2007). *Alcohol policy in Thailand*, Retrieved from <http://www.ias.org.uk/What-we-do/Publication-archive/The-Globe/Issue-2-2007-1-2007/International-Conference-on-Alcohol-held-in-Seoul-Korea/Alcohol-policy-in-Thailand.aspx> Accessed 11<sup>th</sup> April 2014.
- International Center for Alcohol Policies (ICAP). (2014). *Young people and alcohol*. Retrieved from [http://www.icap.org/PolicyTools/ICAPBlueBook/BlueBookModules/11YoungPeopleandAlcohol/tabid/172/Default.aspx#ref\\_58](http://www.icap.org/PolicyTools/ICAPBlueBook/BlueBookModules/11YoungPeopleandAlcohol/tabid/172/Default.aspx#ref_58). Accessed 23<sup>rd</sup> March 2014.
- International Centre for Alcohol Policies (ICAP). (2013). *Young People's Drinking*. Retrieved from <http://www.icap.org/PolicyIssues/YoungPeoplesDrinking/tabid/108/Default.aspx> Accessed 25 June 2014
- International Council of Nurses (ICN). (2006). *The ICN Code of Ethics for Nurses*. Retrieve from [http://www.dsr.dk/ser/Documents/icncode\\_english.pdf](http://www.dsr.dk/ser/Documents/icncode_english.pdf). Accessed 11<sup>th</sup> November 2014.
- Jacob, T., & Johnson, S. (1997). Parenting Influences on Alcohol Abuse and Dependence. *Alcohol Health and Research World*, 21(3), 204-209.
- Järvinen, M., & Østergaard, J. (2008). Governing Adolescent Drinking. *Youth & Society*, 40(3), 377-402.

- Jefferson, T., Jones, L., & Bellis, M. (2007). *Interventions delivered in primary and secondary schools to prevent and/or reduce alcohol use by young people under 18 years old: Epidemiology review and development of an epidemiological model*. Liverpool: National Collaborating Centre for Drug Prevention.
- Johnson, L. D., O'Malley, P. M., & Bachman, J. G. (2001). *National survey results on drug use from the Monitoring the Future study, 1975–2000: Vol. I. Secondary school students* (NIH Publication No. 2000). Rockville, MD: National Institute on Drug Abuse.
- Jones, L., James, M., Jefferson, T., Lushey, C., Morleo, M., Stokes, E., Sumnall, H., Witty, K., & Bellis, M. (2007). *A review of the effectiveness and cost-effectiveness of interventions delivered in primary and secondary schools to prevent and/or reduce alcohol use by young people under 18 years old*. Liverpool: National Collaborating Centre for Drug Prevention.
- Jones, L., Sumnall, H., Witty, K., Wareing, M., McVeigh, J., & Bellis, M. A. (2006). *A review of community-based interventions to reduce substance misuse among vulnerable and disadvantaged young people*. Liverpool: National Collaborating Centre for Drug Prevention.
- Kail, R. V., & Cavanaugh, J. C. (2008). *Human development: A life-span view*. Belmont, CA: Wadsworth, Cengage learning.
- Kask, K., Markina, A., & Podana, Z. (2013). The Effect of Family Factors on Intense Alcohol Use among European Adolescents: A Multilevel Analysis. *Psychiatry Journal*, 2013, 1-12.
- Kim, M., & Mallory, C. (2014). *Statistics for Evidence-Based Practice in Nursing*. Burlington: Jones and Bartlet Learning.
- Kirke, D. M. (2006). *Teenagers and substance use: Social Networks and Peer Influence*. Basingstoke: Palgrave Macmillan.
- Kneale, J. (2001). The place of drink: temperance and the public, 1856–1914. *Social and Cultural Geography*, 2 (1), 43–59.

- Koch, T., & Kralik, D. (2006). *Participatory Action Research in Health Care*. Oxford: Blackwell Publishing.
- Kok, G., Gottlieb, N. H., Commers, M., & Smerecnik, C. (2008). The Ecological Approach in Health Promotion Programs: A Decade Later. *American Journal of Health Promotion*, 22(6): 437-442.
- Krueger, R. A., & Casey, M. A. (2000). *Focus Groups. A Practical Guide for Applied Research* (3rd ed.). Thousand Oaks, CA: SAGE Publications.
- Krueger, R. A., & Casey, M. A. (2014). *Focus Groups: A Practical Guide for Applied Research*. Thousand Oaks, California: SAGE Publications.
- Kumpfer, K. L., Alvarado, R., & Whiteside, H. O. (2003). Family-based interventions for substance use and misuse prevention. *Substance Use and Misuse*, 38 (11–13), 1759–87.
- Kumpfer, K. L. (1998). Selective Prevention Interventions: The strengthening families program', In R. S. Ashery, E. Robertson, & Kumper (1998), *Drug abuse prevention through family interventions, NIDA Research Monograph*, 177: 160–207.
- Kumpfer, K. L., & Alvarado, R. (2003). Family-strengthening approaches for the prevention of youth problem behaviors. *American Psychologist*, 58(6-7), 457-465.
- Kuntsche, E., Knibbe, R., Gmel, G., & Engels, R. (2005). Why do young people drink? A review of drinking motives. *Clinical Psychology Review*, 25(7), 841–861.
- Kuntsche, E., Knibbe, R., Gmel, G., & Engels, R. (2006). Who drinks and why? A review of socio-demographic, personality, and contextual issues behind the drinking motives in young people. *Addictive Behaviors*, 31, 1844–1857.
- Kvale, S. (1996). *Interviews: An Introduction to Qualitative Research Interviewing*. Thousand Oaks, CA: SAGE Publications.
- Langford, J., & McDonagh, D. (Eds.). (2003). *Focus Groups: Supporting Effective Product Development*. London: Taylor & Francis.

- Larson, R., & Brown, J. (2007). Emotional development in adolescence: what can be learned from a high school theater program? *Child Development*, 78(4), 1083-1099.
- Latkin, C. A., & Knowlton, A. R. (2005). Micro-social structural approaches to HIV prevention: a social ecological perspective. *AIDS Care*, 17 (Supplement 1), 102-113.
- Ledoux, S., Miller, P., Choquet, M., & Plant, M. (2002). Family structure, parent-child relationships, and alcohol and other drug use among teenagers in France and the United Kingdom. *Alcohol and Alcoholism*, 37(1), 52-60.
- Liamputtong, P., & Ezzy, D. (2005). *Qualitative Research Methods*. New York: Oxford University Press.
- Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: SAGE Publications.
- Lucie, R., Gauvin, L., & Raine, K. (2011). Ecological Models Revisited: Their Uses and Evolution in Health Promotion Over Two Decades. *Annual Review of Public Health*, 32, 307–326.
- Luna, B., Padmanabhan, A., & O'Hearn, K. (2010). What has fMRI told us about the development of cognitive control through adolescence? *Brain Cognition*, 72(1), 101-113.
- Mackey, T. K., Liang B. A., & Strathdee, S. A. (2013). Digital Social Media, Youth and Nonmedical Use of Prescription Drugs: The Need for Reform. *Journal Medical Internet Research*, 15(7), e 143.
- Mahaarcha, S., & Kittisuksathit, S. (2013). Relationship between Religiosity and Prosocial Behavior of Thai Youth Silpakorn University. *Journal of Social Sciences, Humanities, and Arts*, 13(2), 69-92.
- Marrow, A. J. (1969). *The practical theorist: The life and work of Kurt Lewin*. New York: Basic Book.

- Martin, G. (2005). *Juvenile Justice: Process and system*. Thousand Oaks, CA: SAGE Publications.
- Mason, W. A., & Windle, M. (2001). Family, religious, school and peer influences on adolescent alcohol use: A longitudinal study. *Journal of Studies on Alcohol and Drugs*, 62(1), 44-53.
- McClatchy. (2011). *Aggressive marketing raises alcohol consumption in Thailand*, McClatchy - Tribune Information Services, United States. Retrieved from [http://www.monstersandcritics.com/news/health/news/article\\_1614906.php/Aggressive-marketing-raises-alcohol-consumption-in-Thailand](http://www.monstersandcritics.com/news/health/news/article_1614906.php/Aggressive-marketing-raises-alcohol-consumption-in-Thailand) Accessed 21<sup>st</sup> Feb 2011
- McDonald, J., Grove J., & Youth Advisory Forum Members. (2001). *Youth for Youth: Piecing Together the Peer Education Jigsaw*, Proceeding of the Second International Conference on Drugs and Young People, Melbourne, 4-6 April 2001.
- McKeigue, P. M., & Karmi, G. (1993). Alcohol consumption and alcohol related problems in Afro-Caribbeans and South Asians in the United Kingdom. *Alcohol and Alcoholism*, 28, 1-10.
- McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion program. *Health Education Quarterly*, 15(4), 351-377.
- Merrill, R. M., Folsom, J. A., & Christopherson, S. S. (2005). The influence of family religiosity on adolescent substance use according to religious reference. *Social Behavior and Personality: an international journal*, 33(8), 821-836.
- Miller, N., & Brown, J. (1986). Workshop on action/participatory research. In Zukas, M. (Ed.), *Proceedings of the Sixteenth Standing Conference on University Teaching and Research in the Education of Adults*. Department of Adult and Continuing Education, University of Leeds, Hull, England, pp. 157-166 (ERIC Document Reproduction Service No. Ed 280 995)

- Moolasart, J., & Chirawatkul, S. (2012). Drinking Culture in the Thai-Isaan Context of Northeast Thailand. *Southeast Asian Journal Tropical Medicine and Public Health*, 43(3), 795-807.
- Mulvihill, C., Taylor, L., Waller, S., Naidoo, B., & Thom, B. (2005). *Prevention and reduction of alcohol misuse: Evidence briefing* (2nd ed.). London: Health Development Agency.
- National Advisory Council. (2004). *NIAAA Council Approves Definition of Binge Drinking*. Retrieved from [http://pubs.niaaa.nih.gov/publications/Newsletter/winter2004/Newsletter\\_Number3.pdf](http://pubs.niaaa.nih.gov/publications/Newsletter/winter2004/Newsletter_Number3.pdf) Accessed 23<sup>rd</sup> May 2011.
- National Centre for Social Research and the National Foundation for Educational Research (NCSR and NFER). (2010). *Smoking, drinking and drug use among young people in England in 2006 to 2008*. London: Information Centre for Health.
- National Institute for Health and Clinical Excellence (NICE). (2007). *Interventions in schools to prevent and reduce alcohol use among children and young people*. London: National Institute for Health and Clinical Excellence.
- National Statistics Office. (2005). *Report of Smoking and Alcohol Consumption Survey 2004*. Bangkok: Statistical Forecasting Bureau.
- Neild, B. (2013). *World's 10 best drinking nations*. Retrieved from <http://edition.cnn.com/2013/03/15/travel/best-drinking-nations/> Accessed 25<sup>th</sup> February 2014.
- Neuman, W. L. (2006). *Social research methods: Qualitative and quantitative approaches* (6th ed.). New York: Allyn & Bacon.
- Newman, B., & Newman, P. (1999). *Development through life. A psychosocial approach* (7th ed.). Belmont: Wordsworth Publishing.
- Newman, I. M., Shell, D. F., Li, T., & Innadda, S. (2006). Buddhism and adolescent alcohol use in Thailand. *Substance use & misuse*, 41(13), 1789-1800.

- Ninnart. (2014). *Western Influences on Thai Culture*. Retrieved from [http://www.Thaiwaysmagazine.com/thai\\_article/1923\\_western\\_influence/western\\_influence.html](http://www.Thaiwaysmagazine.com/thai_article/1923_western_influence/western_influence.html) Accessed 23<sup>rd</sup> May 2014.
- Nixon, K., & McClain, J. A. (2010). Adolescence as a critical window for developing an alcohol use disorder: current findings in neuroscience. *Current Opinion Psychiatry*, 23, 227-232.
- O'Brien, R. (2001). *An Overview of the Methodological Approach of Action Research*. Retrieved from <http://web.net/robrien/papers/arfinal.html> Accessed 23<sup>rd</sup> July 2011.
- Oswalt, A. (2008). *Eric Erickson and Child Development*. Retrieved from [http://www.mentalhelp.net/poc/view\\_doc.php?type=doc&id=7927&cn=28](http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=7927&cn=28) Accessed 18<sup>th</sup> October 2014.
- Oswalt, A. (2010). *Erik Erikson and Self-Identity*. Retrieved from [http://www.mentalhelp.net/poc/view\\_doc.php?type=doc&id=41163&cn=1310](http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=41163&cn=1310) Accessed 18<sup>th</sup> October 2014.
- Parahoo, K. (2014). *Nursing Research: Principle, Process and Issue* (3rd ed.). Basingstoke: Palgrave Macmillan.
- Patton, M.Q. (2002). *Qualitative Research & Evaluation Methods* (3rd ed.). Thousand Oaks, London: SAGE Publications.
- Paus, T. (2005). Mapping brain maturation and cognitive development during adolescence. *Trends in Cognitive Science*, 9(2), 60-68.
- Peleg-Oren, N., Saint-Jean, G., Cardenas, G. A., Tammara, H., & Pierre, C. (2009). Drinking Alcohol before Age 13 and Negative Outcomes in Late Adolescence. *Alcoholism-Clinical and Experimental Research*, 33(11), 1966-1972.
- Peters, M., & Robison, V. (1984). The origins and status of action research. *Journal of Applied Behavioral Science*, 20(2), 113-124.



- Peterson, P. L., Hawkins, J. D., Abbott, R. D., & Catalano, R. F. (1994). Disentangling the effects of parental drinking, family management, and parental alcohol norms on current drinking by black and white adolescents. *Journal of research on adolescence*, 4(2), 203-227.
- Pew Research. (2012). *Buddhists*. Retrieved from <http://www.pewforum.org/2012/12/18/global-religious-landscape-buddhist/> Accessed 23<sup>rd</sup> March 2014.
- Phaisal Wisalo Bhikku. (1984). *History of Alcohol Consumption in Thailand*. Bangkok: Health System Research Institute.
- Piaget J. (1971). *Biology and knowledge*. Chicago: University of Chicago Press.
- Plant, M., & Plant, M. (2001). Young people and alcohol. *Nursing Time Research*, 6(6), 887-897.
- Polit, D., & Beck, C. (2004). *Nursing Research principle and methods* (7th ed.). Philadelphia: Lippincott Williams and Wilkins.
- QSR International. (2011). *NVIVO 9 Getting Started*. Retrieved from <http://download.qsrinternational.com/Document/NVivo9/NVivo9-Getting-Started-Guide.pdf> Accessed 24<sup>th</sup> February 2013.
- Radzik, M., Sherer, S., & Neinstein, L. (2007). Psychosocial Development in Normal Adolescents. In L. Neinstein, C. Gordon, D. Katzman, D. Rosen, & E. Woods. *Adolescent Health Care: A Practical Guide* (5th ed.) (pp 27-31). Lippincott, Philadelphia, USA: Williams & Wilkins.
- Ramajitti Institute. (2010). *Money Watch*. Retrieved from [http://www.ramajitti.com/research\\_project\\_money.php](http://www.ramajitti.com/research_project_money.php) Accessed 25<sup>th</sup> April 2013.
- Reason, P., & Bradbury, H. (Eds.). (2008). *The handbook of action research: participative inquiry and practice* (2nd ed.). Thousand Oaks, CA: SAGE Publications.
- Ritson, B. (2011). Alcohol Nation: How to Protect Our Children from Today's Drinking Culture. *Alcohol and Alcoholism*, 46(6), 737.

- Roe, S., & Becker, J. (2005). Drug prevention with vulnerable young people: a review. *Drugs: Education Prevention, and Policy*, 12(2), 85–99.
- Room, R., & Mäkelä, K. (2000). Typologies of the cultural position of drinking. *Journal of Studies on Alcohol and Drugs*, 61(3), 475-483.
- Room, R., Mäkelä, P., Benegal, V., Greenfield, T. K., Hettige, S., Tumwesigye, N. M., & Wilsnack, R. (2012). Times to drink: cross-cultural variations in drinking in the rhythm of the week. *International journal of public health*, 57(1), 107-117.
- Rose, M. (2012). Thailand Average Salary Income Retrieved from <http://www.thailand-blogs.com/2012/11/11/thailand-average-salary-income/>. Accessed 19<sup>th</sup> July 2012.
- Rowe, D. C. (1994). *The limits of family influence: Genes, experience and behaviour*. New York: Guilford Press.
- Rush, S. (2009). *Culture Clash and Accommodation: The effects of western influence on Thailand's indigenous company culture in Bangkok, Thailand*. Masters Proposal Degree of Master of Arts in Organizational Psychology. CA: John F. Kennedy University.
- Sam-angsri, N., Assanangkornchai S, Pattanasattayawong, U., & Muekthong, A. (2010). Health-Risk Behaviors among High-School Students in Southern Thailand. *Journal of the Medical Association of Thailand*, 93(9), 1075-1083.
- Sangsingkeo, P. (1969). Buddhism and some effects on the rearing of children in Thailand. In W Caudill & T. Y. Lin (Eds.), *Mental health research in Asia and the Pacific* (pp. 286-295). Honolulu, Hawaii: East-West Center Press.
- Seigal, M. (2008). *Marvellous Minds: The Discovery of What Children Know*. Oxford: Oxford University Press.
- Shears, J., Edwards, R. W., & Stanley, L. R. (2006). School Bonding and Substance Use in Rural Communities. *Social Work Research*, 30(1), 6–18.

- Sieving, R. E., Maruyama, G., Williams, C. L., & Perry, C. L. (2000). Pathways to adolescent alcohol use: Potential mechanisms of parent influence. *Journal of Research on Adolescence*, 10(4), 489-514.
- Skara, S., & Sussman, S. (2003). A review of 25 long-term adolescent tobacco and other drug use prevention program evaluations. *Preventive Medicine*, 37(5), 451-74.
- Slater, A., & Bremner, G. (2003). *An Introduction to Developmental Psychology*. Oxford: Blackwell Publisher.
- Slater, A., & Muir, D. (1999). *The Blackwell Reader in Developmental Psychology*. Oxford: Blackwell Publisher.
- Small, S. (2010). *Family-Based Prevention Programs*. Retrieved from <http://whatworks.uwex.edu/attachment/FamilyBasedPreventionProgramschapterdraft6-10-10.pdf> Accessed 6<sup>th</sup> of July 2014.
- Smith, L., & Foxcroft, D. (2009). *Drinking in the UK: An exploration of trends*. Retrieved from <http://www.jrf.org.uk/sites/files/jrf/UK-alcohol-trends-FULL.pdf> Accessed 27<sup>th</sup> March, 2014.
- Smith, P. K., Cowie, H., & Blades, M. (2003). *Understanding Children's Development* (4th ed.). Oxford: Blackwell Publisher.
- Smith, P. K., Cowie, H., & Blades, M. (2011). *Understanding children's development* (5th ed.). West Sussex: John Wiley & Sons Ltd.
- Somerville, L. H., & Casey, B. J. (2010). Developmental neurobiology of cognitive control and motivational systems. *Current Opinion in Neurobiology*, 20(2), 236-241
- Sondhi, A., & Turner, C. (2011). *The influence of family and friends on young people's drinking*. Retrieved from <http://www.jrf.org.uk/sites/files/jrf/influencing-young-peoples-drinking-summary.pdf> Accessed 19<sup>th</sup> August 2013.

- Soonthorn, S., Suttisai, W., Homhuan, S., & Phothisak, A. (2014). The Change to Modernization and the Sustainable People in Maha Sarakham Province. *Merit Research Journal of Education and Review*, 2(6), 104-112.
- Stead, M., McDermott, L., Gordon, R., Angus, K., & Hastings, G. (2006). *A review of the effectiveness of social marketing alcohol, tobacco and substance misuse interventions. National Social Marketing Centre, Report 3*. London: National Social Marketing Centre.
- Steinberg, L. (2005). Cognitive and affective development in adolescence. *Trends in Cognitive Sciences*, 9(2), 69-74.
- Sternberg, R. J., & Jarvin, L. (2003). Alfred Binet's contributions as a paradigm impact in psychology. In R.J. Sternberg (Ed.), *The anatomy of impact: What makes the great works of psychology treat*. Washington, DC: American Psychological Association.
- Stigler, M. H., Perry, C. L., Komro, K. A., Cudeck, R., & Williams, C. L. (2006). Teasing apart a multiple component approach to adolescent alcohol prevention: what worked in Project Northland? *Prevention Science*, 7, 269 – 280.
- Stothard, B., & Ashton, M. (2000). Education's uncertain saviour. *Drug and Alcohol Findings*, 3, 4–7, 16–20.
- Stringer, E. T. (1999). *Action Research* (2nd ed.). Thousand Oaks, CA: SAGE Publications.
- Suriyawongpaisal, P., Plitapolkarnpim, A., & Tawonwanchai, A. (2002). Application of 0.05 percent legal blood alcohol limits to traffic injury control in Bangkok. *Journal Medical Association Thailand*, 85, 496-500.
- Susman, G. (1983). Action Research: A Socio-Technical Systems Perspective. In G. Morgan (Ed.), *Beyond Method: Strategies for social research* (pp 95-113). Newbury Park: SAGE Publications.

- Susman, G., & Evered, R. D. (1978). An Assessment of the Scientific Merits of Action research. *Administrative Science Quarterly*, 23(4), 582-603.
- Suwanlert, S. (1974). Some personality characteristics of Thai students. In W P. Lebra (Ed.), *Youth, socialization, and mental health in Asia and the Pacific* (pp. 75-84). Honolulu: University Press of Hawaii.
- Szmigin, I., Griffin, C., Mistral, W., Bengry-Howell, A., Weale, L., & Hackley, C. (2008). Re-framing “binge drinking” as “calculated hedonism”: empirical evidence from the UK. *International Journal of Drugs Policy*, 19(5), 359–366.
- Taylor, D., Bury, M., Campling, N., Carter, S., Garfied, S., Newbould, J., & Rennie, T. (2007). *The influence of social and cultural context on the effectiveness of health behaviour change interventions in relation to diet, exercise and smoking cessation*. London: National Institute for Clinical Excellence.
- Thai National Statistical Office. (2007). *Alcohol drinking*. Retrieved from <http://web.nso.go.th/survey/smoke/ad.pdf> Accessed 23<sup>rd</sup> January 2011.
- Thai National Statistical Office. (2011). *Alcohol drinking habit*. Retrieved from <http://web.nso.go.th/en/survey/health/data/Alcoholic%20Drinking%20Habit.pdf> Accessed 17<sup>th</sup> January 2013.
- Thai PBS. (2014). *Alcohol consumption in Thailand*. Retrieved from <http://englishnews.thaipbs.or.th/infographic/alcohol-consumption-thailand/> Accessed 20<sup>th</sup> June 2014.
- Thamarangsri, T. (2006). Thailand: alcohol today. *Addiction*, 101, 783-787.
- Thavorncharoensap, M., Teerawattananon, Y., Yothasamut J., Lertpitakpong, C., Thitiboonsuwan, K., Neramitpitagkul, P., & Chaikledkaew, U. (2010). The economic costs of alcohol consumption in Thailand. *BMC Public Health*, 10, 323-335.

- The National Alcohol Control Committee. (2013). *Alcohol Beverage Control Act B.E. 2551 (2008)*. Retrieved from [http://www.thaiantialcohol.com/uploads/files/content/download/5\\_0977a95e3c8c.pdf](http://www.thaiantialcohol.com/uploads/files/content/download/5_0977a95e3c8c.pdf) Accessed 23<sup>rd</sup> May 2013.
- The National Alcohol Control Committee. (2013). *Alcohol Beverage Control Act B.E. 2551 (2008)*. Retrieved from [http://www.thaiantialcohol.com/uploads/files/content/download/5\\_0977a95e3c8c.pdf](http://www.thaiantialcohol.com/uploads/files/content/download/5_0977a95e3c8c.pdf) (in Thai) Accessed 20<sup>th</sup> March 2014.
- The National Statistical Office of Thailand. (2011). *The 2011 Survey on Status of Society and Culture*. Retrieved from [http://web.nso.go.th/en/survey/data\\_survey/570703\\_Survey\\_%20on\\_%20Status\\_%20of\\_%20Societ\\_11.pdf](http://web.nso.go.th/en/survey/data_survey/570703_Survey_%20on_%20Status_%20of_%20Societ_11.pdf) Accessed 20<sup>th</sup> April 2012.
- The UK Data Protection Act. (1998). *Data Protection Act*. Retrieved from <http://www.legislation.gov.uk/ukpga/1998/29/enacted> Accessed 24<sup>th</sup> November 2014.
- The world Buddhist University. (2002). *Buddhism in Thailand*. Retrieved from [www.buddhanet.net/pdf\\_file/buddhinthai.pdf](http://www.buddhanet.net/pdf_file/buddhinthai.pdf) Accessed 20<sup>th</sup> March 2014.
- Thomas, G., Reifman, A., Barnes G. M., & Farrell, M. P. (2000). Delayed onset of drunken- ness as a protective factor for adolescent alcohol misuse and sexual risk taking: a longitudinal study. *Deviant Behaviour*, 21(2), 181-210.
- Thomas, R. M. (2005). *Comparing theories of a child development* (6th ed.). New York: New York University Press.
- Udas, K. (1998). Participatory Action Research as Critical Pedagogy. *Systemic Practice and Action Research*, 11(6), 599-628.
- United Nation. (2004). *World youth reports: The global situation of young people*. New York: The United Nations.
- Valente, T. W., Ritt-Olson, A., Stacy, A., Unger, J. B., Okamoto, J., & Sussman, S. (2007). Peer acceleration: effects of a social network tailored substance abuse prevention program among high-risk adolescents. *Addiction*, 102(11), 1804–1815.

- Valentine, G., Jayne, M., Gould, M., & Keenan, J. (2010). *Family Life and Alcohol Consumption: The Transmission of Drinking Cultures*. York: Joseph Rowntree Foundation.
- Van Der Vorst, H., Engels, R. C., Dekovic, M., Vermulst, A., & Meeus, W. (2006). Parental attachment, parental control and early development of alcohol use: A longitudinal study. *Psychology of Addictive Behaviors*, 20(2), 107-116.
- Vantamay, S. (2009). Alcohol Consumption among University Students: Applying a Social Ecological Approach for Multi-Level Preventions. *Southeast Asian Journal of Tropical Medicine and Public Health*, 40(2), 354-369.
- Velleman, R. (2009). *Influence on how do children and young people learn about and behave towards alcohol: A major review of the literature for the Joseph Rowntree Foundation*. Bath: University of Bath. Retrieved from <http://www.bath.ac.uk/health/mhrdu/Velleman-JRF.pdf> Accessed 28<sup>th</sup> May 2013.
- Webster, R. A., Hunter, M., & Keats, J. A. (2002). Evaluating the effects of a peer support programme on adolescents' knowledge, attitudes and use of alcohol and tobacco. *Drug & Alcohol Review*, 21(1), 7-16.
- Wechsler, H., Lee, J. E., Nelson, F. N., & Kuo, M. (2002). Underage college students' drinking behavior, access to alcohol, and the influence of deterrence policies. *Journal of American College Health*, 50(5), 223 – 236.
- Weiss, R. (1994). *Learning From Strangers: The Art and Method of Qualitative Interview Studies*. New York: The Free Press.
- Weisz, J. R., Suwanlert, S., Chaiyasit, W., Weiss, B. Achenbach, T. M., & Eastman, K. L. (1993). Behavioural and Emotional Problems among Thai and American Adolescents: Parent Reports for Ages 12-16. *Journal of Abnormal Psychology*, 102(3), 395-403.
- Weiten, W. (1992). *Psychology: Themes and Variations* (2nd ed.). Pacific Grove, CA: Brooks/Cole Publishing Company.

- Wibulpolprasert, S. (2005). *Thailand Health Profile 2001-2004*. Bangkok: Express Transportation Organization Publishing.
- Williams B., Davies L., & Wright V. (2010). *Children, Young People and Alcohol*. Retrieved from [http://alcoholeducationtrust.org/resources/facts/youth drinking UKsurvey2010DCSF.pdf](http://alcoholeducationtrust.org/resources/facts/youth_drinking_UKsurvey2010DCSF.pdf) Accessed 28<sup>th</sup> May 2013.
- Wilsnack, R. W., Wilsnack, S. C., Kristjanson, A. F., Vogeltanz-Holm, N. D., & Gmel, G. (2009). Gender and alcohol consumption: patterns from the multinational GENACIS project. *Addiction*, 104(9), 1487-1500.
- Windle, M. (2000). A latent growth curve model of delinquent activity among adolescents. *Applied Developmental Science*, 4(4), 193–207.
- Winpenny, E. M, Marteau, T. M., & Nolte, E. (2014). Exposure of Children and Adolescents to Alcohol Marketing on Social Media Websites. *Alcohol and Alcoholism*, 49(2), 154-159.
- Winpenny, E., Patil, S., Elliott, M., Villalba van Dijk, L., Hinrichs, S., Marteau, T., & Nolte, E. (2012). *Assessment of young people's exposure to alcohol marketing in audiovisual and online media*. Retrieved from [http://ec.europa.eu/health/alcohol/docs/alcohol\\_rand\\_youth\\_exposure\\_marketing\\_en.pdf](http://ec.europa.eu/health/alcohol/docs/alcohol_rand_youth_exposure_marketing_en.pdf) Accessed 16<sup>th</sup> July 2014.
- World Health Organization (WHO). (2004). Global Status Report: Alcohol Policy. Retrieved from [http://www.who.int/substance\\_abuse/publications/global\\_status\\_report\\_2004\\_overview.pdf](http://www.who.int/substance_abuse/publications/global_status_report_2004_overview.pdf) Accessed 10<sup>th</sup> April 2014.
- World Health Organization (WHO). (2009). *Global Strategy to Reduce Harmful Use of Alcohol*. Report on the WHO Regional Technical Consultation 24- 26 February 2009, Nonthaburi, Thailand. Retrieved from [http://www.who.int/substance\\_abuse/msbsearalconsult.pdf](http://www.who.int/substance_abuse/msbsearalconsult.pdf) Accessed 9<sup>th</sup> March 2013.
- World Health Organization (WHO). (2010). *Global strategy to reduce the harmful use of alcohol*. Retrieved from [http://www.who.int/substance\\_abuse/msbalcstrategy.pdf](http://www.who.int/substance_abuse/msbalcstrategy.pdf). Accessed 21<sup>st</sup> July 2012.



- World Health Organization (WHO). (2011). *Global status report on alcohol and health*. Retrieved from [http://www.who.int/substance\\_abuse/publications/global\\_alcohol\\_report/msbgsruprofiles.pdf](http://www.who.int/substance_abuse/publications/global_alcohol_report/msbgsruprofiles.pdf) Accessed 20<sup>th</sup> March 2014.
- World Health Organization (WHO). (2012). *Youth violence and alcohol fact sheet*. Retrieved from [http://www.who.int/violence\\_injury\\_prevention/violence/world\\_report/factsheets/ft\\_youth.pdf](http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/ft_youth.pdf) Accessed 26<sup>th</sup> August 2013.
- World Health Organization (WHO). (2014). *Global status report on alcohol and health*. Retrieved from [http://www.who.int/substance\\_abuse/publications/global\\_alcohol\\_report/msb\\_gsr\\_2014\\_1.pdf?ua=1](http://www.who.int/substance_abuse/publications/global_alcohol_report/msb_gsr_2014_1.pdf?ua=1) Accessed 23<sup>rd</sup> January 2015.
- World Health Organization Regional Office for Europe. (2013). *Status Report on Alcohol and Health in 35 European Countries*. Retrieved from [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0017/190430/Status-Report-on-Alcohol-and-Health-in-35-European-Countries.pdf](http://www.euro.who.int/__data/assets/pdf_file/0017/190430/Status-Report-on-Alcohol-and-Health-in-35-European-Countries.pdf) Accessed 21<sup>st</sup> July 2014.
- Worthman, C. M. (2010). The Ecology of Human Development: Evolving Models for Cultural Psychology. *Journal of Cross-Cultural Psychology*, 41(4), 546–562.
- Young, S. Y., Hansen, C. J., Gibson, R. L., & Ryan, M. A. (2006). Risky alcohol use, age at onset of drinking, and adverse childhood experiences in young men entering the US marine corps. *Archives of Pediatrics & Adolescent Medicine*, 160(12), 1207-1214.
- Zeigler, D. W., Wang, C. C., Yoast, R. A., Dickinson, B. D., McCaffree, M. A., Robinowitz, C. B., & Sterling, M. L. (2005). The neurocognitive effects of alcohol on adolescents and college students. *Preventive Medicine*, 40, 23 – 32.

## Appendices

### Appendix A: The questionnaire for survey study

#### **Alcohol consumption behaviour of young people in Thailand: Perspectives of stakeholders in Petchaburi Province**

**Thank you for helping us with this survey. We hope that you enjoy filling in the questionnaire. Please do not write your name and surname on this questionnaire. Personal information will be anonymous and not be listed in the research. The purpose is to prevent the violation of personal privacy and to comply with research ethics.**

#### **Who will see my answers?**

Only the survey research teams at the University of Edinburgh will see the completed questionnaires, no-one else will see your answers. Once you have filled in the questionnaire, put it in the envelope provided and seal it. It will then be passed onto the survey team.

#### **How to fill in the questionnaire**

- Please fill in the questionnaire using black or blue pen.
- Most questions can be answered by putting a cross in the box next to the answer that applies to you.
- Please only cross one box for each question, unless asked to cross more than one box. If it is difficult to choose, then cross the answer that is true for most of the time.
- Sometimes you are asked to write in your answer in your own words, please write this in the space provided.
- Sometimes you'll be asked to write in a number e.g. the number of times you have done something. If you are unsure, please use your best guess, instead of missing out the answer.
- When writing in a number, please write in figures not words e.g. 18.
- If you cross a box and want to change this, please score over your first answer and then cross your new answer in the box that applies.

#### **FIRST A FEW DETAILS ABOUT YOURSELF**

1) Are you male or female?

- ☐ 1. Male  
☐ 2. Female

2) What school year are you in?

- ☐ 1. Secondary 4  
☐ 2. Secondary 5  
☐ 3. Secondary 6

3) How old are you?

☐ .....years

4) What is your Grade Point Average (GPA).....

5) What is your religion?

☐ 1. Buddhist

☐ 2. Christian

☐ 3. Muslim

☐ 4. Other (Please write in).....

6) How much is your monthly expenditure? .....Baht

7) How much is your family income? .....Baht

8) How are you family member relationships?

☐ 1. Good relationship

☐ 2. Fair relationship

☐ 3. Poor relationship

9) What is your living arrangement?

☐ 1. living with parents/guardians

☐ 2. living in cousin's house

☐ 3. living with someone other than your own parents

☐ 4. living in privately rented dormitory near school

10) Which one of these do you think you want to be doing when you leave school?  
(Please cross ONE box only)

☐ 1. University

☐ 2. Further Education College

☐ 3. Apprenticeship/trade

☐ 4. Youth Training/Skill Seekers

☐ 5. Working

☐ 6. Unemployed

☐ 7. Don't know

☐ 8. Other (Please write in).....

11) Do you have some family members who have drunk alcohol?  
(You can cross MORE THAN ONE box if this applies to you)

☐ 1. Father

- ☐ 2. Mother
- ☐ 3. Sibling: sister/brother
- ☐ 4. Cousin/relative
- ☐ 5. Grandfather/grandmother
- ☐ 6. None
- ☐ 7. Other (Please write in).....

12) How often do your family members consume alcohol?

- ☐ 1. Every day
- ☐ 2. Twice a week
- ☐ 3. Once a week
- ☐ 4. Once a fortnight
- ☐ 5. Once a month
- ☐ 6. A few times a year
- ☐ 7. My family members never drink alcohol

13) How often have your family members been drunk?

- ☐ 1. Every day
- ☐ 2. Twice a week
- ☐ 3. Once a week
- ☐ 4. Once a fortnight
- ☐ 5. Once a month
- ☐ 6. A few times a year
- ☐ 7. My family members have never been drunk

### THESE NEXT QUESTIONS ARE ABOUT ALCOHOL

### QUESTIONS ABOUT HOW OFTEN YOU DRINK

1) Have you ever had a proper alcoholic drink - a whole drink, not just a sip during the previous 30 days?

- ☐ 1. Yes
- ☐ 2. No

2) How often do you USUALLY have an alcoholic drink?

(Please cross box which closely represents your answer)

- ☐ 1. Every day
- ☐ 2. Twice a week
- ☐ 3. Once a week
- ☐ 4. Once a fortnight
- ☐ 5. Once a month
- ☐ 6. A few times a year
- ☐ 7. I never drink alcohol

3) On which of these days during the previous 30 days did you have an alcoholic drink? (You can cross MORE THAN ONE box if this applies to you)






- ☐ 1. Monday
- ☐ 2. Tuesday
- ☐ 3. Wednesday
- ☐ 4. Thursday
- ☐ 5. Friday
- ☐ 6. Saturday
- ☐ 7. Sunday
- ☐ 99. Not relevant for me

<b>QUESTIONS ABOUT WHAT YOU DRINK</b>
---------------------------------------

5) During the previous 30 days, how much BEER, LAGER and CIDER have you drunk? (Please cross only ONE box)

- ☐ 1. Have not drunk Beer, Lager or Cider during the previous 30 days
- ☐ 2. Less than half a pint
- ☐ 3. Half a pint or more
- ☐ 99. Not relevant for me

6) Write in the boxes below the number of pints, half pints, large cans, small cans and bottles of BEER, LAGER and CIDER drunk during the previous 30 days.





<input type="text"/>	Pints	
<input type="text"/>	Half pints	
<input type="text"/>	Large cans	
<input type="text"/>	Small cans	
<input type="text"/>	Bottles	

☐ 99. Not for me

7) During the previous 30 days how much SHANDY have you drunk?  
(Please cross only ONE box)

- ☐ 1. Have not drunk Shandy during the previous 30 days
- ☐ 2. Less than half a pint
- ☐ 3. Half a pint or more
- ☐ 99. Not relevant for me

8) Write in the boxes below the number of pints, half pints, large cans and small cans of SHANDY drunk during the previous 30 days.

<input type="text"/>	Pints	
<input type="text"/>	Half pints	
<input type="text"/>	Large cans	
<input type="text"/>	Small cans	

☐ 99. Not relevant for me

9) During the previous 30 days, how much WINE have you drunk?  
(Please cross only ONE box)

- ☐ 1. Have not drunk wine during the previous 30 days
- ☐ 2. Less than a glass
- ☐ 3. One glass or more
- ☐ 99. Not relevant for me

10) Write in the box below the number of glasses of WINE drunk during the previous 30 days.

<input type="text"/>	Glasses	
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☐ 99. Not relevant for me

11) During the previous 30 days, how much FORTIFIED/DESSERT or TONIC WINE have you drunk? This includes drinks such as: Buckfast; Thunderbird; Port.  
(Please cross only ONE box)

- ☐ 1. Have not drunk Fortified/Dessert/Tonic wine during the previous 30 days
- ☐ 2. Less than a glass
- ☐ 3. One glass or more

☐ 99. Not relevant for me

12) Write in the box below the number of glasses of FORTIFIED/DESSERT/TONIC WINE (e.g. Buckfast, Thunderbird, Port) drunk during the previous 30 days.

Glasses



☐ 99. Not relevant for me

13) During the previous 30 days, how much MARTINI and SHERRY have you drunk?

(Please cross only ONE box)

☐ 1. Have not drunk Martini or Sherry during the previous 30 days

☐ 2. Less than a glass

☐ 3. One glass or more

☐ 99. Not relevant for me

14) Write in the box below, the number of glasses of MARTINI and SHERRY drunk in the last 30 days.

Glasses



☐ 99. Not relevant for me

15) During the previous 30 days, how much SPIRITS and Liqueurs (e.g. Whisky, Vodka, Gin, Tequila, Baileys, Tia Maria) have you drunk? (Please cross only ONE box)

☐ 1. Have not drunk Spirits or Liqueurs during the previous 30 days

☐ 2. Less than a glass

☐ 3. One glass or more

☐ 99. Not relevant for me

16) Write in the box below, the number of glasses of SPIRITS and liqueurs (e.g. Whisky, Vodka, Gin, Tequila, Baileys, Tia Maria) drunk during the previous 30 days.

Glasses





☐ 99. Not relevant for me

17) During the previous 30 days, how many ALCOPOPS or PRE-MIXED ALCOHOLIC DRINKS (e.g. Bacardi Breezer, Smirnoff Ice) have you drunk?

(Please cross only ONE box)

- ☐ 1. Have not drunk Alcopops or pre-mixed alcoholic drink during the previous 30 days
- ☐ 2. Less than a bottle
- ☐ 3. One bottle or more
- ☐ 99. Not relevant for me

18) Write in the boxes below the number of cans and bottles of ALCOPOPS or PRE-MIXED ALCOHOLIC DRINKS (e.g. Bacardi Breezer, Smirnoff Ice) drunk during the previous 30 days.

<input type="text"/>	Cans	
<input type="text"/>	Bottles	

- ☐ 99. Not relevant for me

<b>QUESTIONS ABOUT THE EFFECT OF DRINKING</b>
---

19) Have you been drunk during the previous 30 days?

- ☐ 1. Yes
- ☐ 2. No

20) Have you deliberately tried to get drunk during the previous 30 days?

- ☐ 1. Yes
- ☐ 2. No

21) Have you felt ill, sick or vomited from drinking too much alcohol during the previous 30 days?

- ☐ 1. Yes
- ☐ 2. No

22) Have you ever been really drunk? (Please cross only ONE box)

- ☐ 1. No, never
- ☐ 2. Yes, once
- ☐ 3. Yes, 2-3 times
- ☐ 4. Yes, 4-10 times



☐ 5. Yes, more than 10 times

23) During the previous 30 days, how many times did you have five or more drinks on the same occasion? (Please cross only ONE box)

☐ 1. 4 or more times

☐ 2. 3 times

☐ 3. twice

☐ 4. once

☐ 5. I have not had 5 or more drinks on the same occasion during the last 30 days

☐ 6. I have never had 5 or more drinks on the same occasion

☐ 99. Not relevant for me

24) In the past year, as a result of drinking alcohol have you ...?  
(Please cross ONE box on EACH LINE)

Results	1=Never	2=Sometimes	3=Often
R1. Had an argument			
R2. Had a fight, violent event, assaulted			
R3. Visited an A&E department			
R4. Been admitted to hospital overnight			
R5. Had an injury that needed to be seen by a doctor			
R6. Stayed off school			
R7. Been sick: nausea and vomiting			
R8. Tried any drugs, substance abuse: smoking, amphetamine use, and other drugs			
R9. Been in trouble with the police			
R10. Been taken home by police			
R11. Been involved with traffic problems: accidents, driving after drinking			
R12. Carried weapons			
R13. Rape			
R14. Emotional problems: Depression			
R15. Having suicidal tendencies: attempting suicide			
R16. Having sexual intercourse: never used a condom, and resulted in pregnancy, have been pregnant or made someone pregnant			
R17. Poor self-esteem			
R18. Poor school performance			
R19. Having a hangover			

## QUESTIONS ABOUT WHERE YOU DRINK AND WITH WHOM

25) When you drink alcohol, where are you USUALLY...?  
(You can cross MORE THAN ONE box if this applies to you)

- ☐ 1. In a pub or bar
- ☐ 2. In a club or disco
- ☐ 3. At a party with friends
- ☐ 4. At my home
- ☐ 5. At someone else's home
- ☐ 6. Out on the street, in a park or other outdoor area
- ☐ 7. Somewhere else (Please write in).....
- ☐ 99. Not relevant for me

26) When you drink alcohol, how often are you with the following people?  
(Please cross ONE box in EACH LINE)

People	1=Never	2=Rarely	3=Sometimes	4=Often	5=Don't have or don't see this person
W1. Mother					
W2. Father					
W3. Brother					
W4. Sister					
W5. Girlfriend/boyfriend					
W6. Relative e.g. uncle, aunt					
W7. Best friend					
W8. Gang					
W9. I drink alcohol alone					

27) What about your friends (Close friends) - how many of them drink alcohol?  
(Please cross only ONE box)

- ☐ 1. All or almost all
- ☐ 2. More than half
- ☐ 3. Half
- ☐ 4. Less than half
- ☐ 5. Almost none
- ☐ 6. None

## QUESTIONS ABOUT BUYING ALCOHOL

28) If you buy alcohol, where do you USUALLY buy it?  
(Please cross only ONE box)

- ☐ 1. I never buy alcohol
- ☐ 2. In a pub or bar
- ☐ 3. In a club or disco
- ☐ 4. From an off-licence
- ☐ 5. From a shop
- ☐ 6. From a supermarket
- ☐ 7. From a friend/relative
- ☐ 8. From someone else (Please write in) .....
- ☐ 9. From somewhere else Please write in) .....
- ☐ 99. Not relevant for me

29) During the previous 30 days, have you bought or tried to buy alcohol from a shop, supermarket, or off-licence? (Please cross only ONE box)

- ☐ 1. Yes - I bought some alcohol
- ☐ 2. Yes - I tried to buy alcohol but was refused
- ☐ 3. No - I did not buy or try to buy alcohol from a shop, supermarket or off-licence
- ☐ 4. No - I have **Never** tried to buy alcohol from a shop, supermarket or off-licence

30) During the previous 30 days, have you bought or tried to buy alcohol in a pub, bar or club?  
(Please cross only ONE box)

- ☐ 1. Yes - I bought some alcohol
- ☐ 2. Yes - I tried to buy alcohol but was refused
- ☐ 3. No - I did not buy or try to buy alcohol from a pub, bar or club
- ☐ 4. No - I have **Never** tried to buy alcohol from a pub, bar or club

31) Have you got anyone else to buy any alcohol for you during the previous 30 days?

- ☐ 1. Yes
- ☐ 2. No

2) How much do you spend money on your drinks in one occasion?  
(Please cross only ONE box)

- ☐ 1. Below 100 Baht
- ☐ 2. 100-200 Baht
- ☐ 3. 201-400 Baht
- ☐ 4. More than 400 Baht
- ☐ 99. Not relevant for me

<b>QUESTIONS ABOUT DRINKING AND YOUR FAMILY ATTITUDE</b>
--

33) How does your family feel about you drinking alcohol?  
(Please cross only ONE box)

- ☐ 1. They don't like it
- ☐ 2. They don't mind
- ☐ 3. They don't know I drink alcohol
- ☐ 4. I don't know
- ☐ 99. Not relevant for me

34) How do you think your family would feel if you started drinking alcohol?  
(Please cross only ONE box)

- ☐ 1. They would be upset or angry
- ☐ 2. They wouldn't mind
- ☐ 3. I don't know
- ☐ 99. Not relevant for me

35) Do your parents/guardians allow you to drink alcohol at home?  
(Please cross only ONE box)

- ☐ 1. Yes, always
- ☐ 2. Yes, sometimes
- ☐ 3. No, never

<b>QUESTIONS ABOUT WHY YOU DRINK</b>
--------------------------------------

36) What are the causes of your drinking?

(You can cross MORE THAN ONE box if this applies to you)

- ☐ 1. Relatives drinking: father drinking, mother drinking, sibling drinking
- ☐ 2. Peer pressure, peer drinking, in a gang
- ☐ 3. Tension Reduction: broken heart, grief and loss, loneliness etc.
- ☐ 4. Attitude toward alcohol use: supportive attitude toward alcohol use, acting like a man, enjoyment
- ☐ 5. Perceived susceptibility of alcohol use
- ☐ 6. Perceived self-efficacy
- ☐ 7. Accessibility of alcohol around university
- ☐ 8. Accessibility of alcohol around community
- ☐ 9. Exposure to anti-alcohol campaign
- ☐ 10. Exposure to alcohol advertising
- ☐ 11. Benefit: it's good for health
- ☐ 99. Not relevant for me

## Appendix B: The research Ethics Approval by The School of Health in Social Science, The University of Edinburgh

The University of Edinburgh  
College of Humanities and Social Science

### SCHOOL OF HEALTH IN SOCIAL SCIENCE

#### APPROVAL BY SUBJECT AREA RESEARCH ETHICS TEAM/ CO-ORDINATOR (LEVEL 2)

<b>Name/s of Researcher/s:</b>	Thanee Glomjai
<b>Proposed Title of Research:</b>	Alcohol consumption behaviours of young Thai people: Perspective of stakeholders in Petchaburi Province, Thailand
<b>Funding Body (if appropriate):</b>	The Royal Thai Government
<b>General Comments:</b>	
<b>Outcome: (please tick box)</b>	<b>APPROVED</b> ✓
<b>If approved with conditions, name of person to oversee these:</b>	
<p>The above research proposal has been approved by the subject area research ethics team/co-ordinator.</p> <p>Signed: <u>Lorna Sheal</u> ..... (Lorna Sheal on behalf of Professor Kath Melia)</p> <p>Date: <u>04/08/11</u> .....</p>	

## Appendix C: The research Ethics Approval by The Secondary Education Service Area Office 10, Thailand



The Secondary Education Service Area Office 10, Thailand

The Ethical Review Committee for Research in Human Subjects

**Name of Researcher:** Mr. THANEE GLOMJAI

**Research Title:** Alcohol consumption behaviours of young Thai people: Perspectives of stakeholders in Petchaburi Province, Thailand

**Principle Investigator:** Mr. Prawit Lakboon

**General Comments:**

The Ethical Review Committee for Research in Human Subjects of The Secondary Education Service Area Office 10, Thailand has reviewed the protocol and approved for the research study as above mention. The result of the ethics is no condition.

**Outcome:**

The above research proposal has been **Approved** by the subject area research ethics team.

Signed:  ..... Chairman  
(Mr. Prawit Lakboon)

Date of Approval ..... 01 / 11 / 11 .....

## Appendix D: Information sheet and informed consent form

### Sheet One: Parents or guardians

Nursing Studies  
SCHOOL OF HEALTH IN SOCIAL SCIENCE  
The University of Edinburgh  
Medical School, Teviot Place  
Edinburgh EH8 9AG  
Tel. 0131 650 3889  
Fax 0131 650 3891

### Informed Consent Form

This informed consent form is for parents of adolescent girls and boys participating in the research titled, "*Alcohol consumption behaviour of young people in Thailand: Perspectives of stakeholders in Petchaburi Province.*"

**Name of Principle Researcher:** Mr. Thanee Glomjai

**Name of Organization:** The University of Edinburgh

**Name of Sponsor:** The Royal Thai Government

**Name of Project:** *Alcohol consumption behaviour of young people in Thailand: Perspectives of stakeholders in Petchaburi Province*

### Part I: Information Sheet

#### Introduction

I am Mr. Thanee Glomjai, a PhD research student of The School of Health in Social Science, University of Edinburgh, United Kingdom. I am doing a research study which might help you do more to help teenagers become and stay healthier. In my research I will talk to many teenagers, both girls and boys, and ask them a number of questions. Whenever researchers study children, we talk to the parents and ask them for their permission. After you have heard more about the study, and if you agree, then the next thing I will do is ask your daughter/son for their agreement as well. Both of you have to agree independently before I can begin. You do not have to decide today whether or not you agree to have your child participate in this research. Before you decide, you can talk to anyone you feel comfortable with.

In this information sheet, I will give you the information about the research's purpose, participants, protocol, risks and discomforts, benefits, incentives, confidentiality, sharing of research findings, right to refuse or withdraw, and contact person. There may be some words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask me or the other researchers.



**Purpose**

In this study I will talk to teenage girls and boys about what they know about the young people's alcohol consumption behaviours and appropriate prevention strategies. I will invite them to share their knowledge and understanding with us so that we can find ways of meeting their needs at the local clinics, community and school.

**Type of Research Intervention**

A survey, focus groups or in-depth interviews

**Selection of Participants**

I would like to talk to many young people about their experiences, knowledge and opinions, and what information or services they want for themselves. I would like to ask your daughter/son to participate because she/he is a teenager and studies in the school in this community where there is definitely shown a high rate of alcohol consumption in young people.

**Voluntary Participation**

You do not have to agree that your daughter/son can talk to us. You can choose to say no and any services that you and your family receive at this community will not change. I know that the decision can be difficult when it involves your children. And, it can be especially hard when the research includes sensitive topics like alcohol consumption. You can ask as many questions as you like and we take the time to answer them. You don't have to decide today. You can think about it and tell me what you decide later.

**Protocol**

Questionnaire and/or focus group:

Your daughter/son will take part in a survey and/or discussion with 7-10 other young people. This discussion will be guided by *Mr. Thanee Glomjai*.

**Duration**

I will ask your child to participate in a discussion which will take about 1 <sup>1</sup>/<sub>2</sub> to 2 hours of her/his time. I can do this outside of school/work hours.

**Risks and Discomforts**

There is no risk that your son/daughter is sharing some personal or confidential information. Occasionally, he/she may feel uncomfortable talking about some of the topics; however, I do not wish this to happen. He/she may refuse to answer any question or not take part in a portion of the discussion if he/she feels the questions are too personal or if talking about them makes him/her uncomfortable. I will not be sharing with you either the questions I ask or the responses given to us by your child.

**Benefits**

There will be no immediate and direct benefit to your child or to you, but your child's participation is likely to help us find out more about the health needs of teenage girls and boys and I hope that these will help the stakeholders to meet those needs better in the future. Their information will encourage the best strategies to control alcohol

consumption behaviour of young people in this community. Moreover it can generate information and be useful to the other communities.

### **Incentives**

Your daughter/son will not be provided with any payment to take part in the research.

### **Confidentiality**

I will not be sharing information about your son or daughter outside of the research team. The information that we collect from this research project will be kept confidential. Information about your child that will be collected from the research will be put away and no-one but the researchers will be able to see it. Any information about your child will have a number on it instead of his/her name. Only the researchers will know what his/her number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone except teachers.

In cases of focus group discussions, I will ask your child and others in the group not to talk to people outside the group about what was said in the group. I will, in other words, ask each participant to keep what was said in the group confidential. You should know, however, that we cannot stop or prevent participants who were in the group from sharing things that should be confidential.

### **Sharing of Research Findings**

At the end of the study, I will be sharing what we have learnt with the participants and with the community. I will do this by meeting first with the participants and then with the larger community. A written report will also be given to the participants which they can share with their families. I will also publish the results in order that other interested people may learn from my research.

### **Right to refuse or withdraw**

You may choose not to have your child participate in this study and your child does not have to take part in this research if she/he does not wish to do so. Choosing to participate or not will not affect either your own or your child's future study at the school in any way. You and your child will still have all the benefits that would otherwise be available at this school. Your child may stop participating in the discussion at any time that you or she/he wish without either of you losing any of your rights here.

### **Who to Contact**

If you have any questions you may ask them now or later, even after the study has started. If you wish to ask questions later, you may contact any of the following:

**Mr. Thanee Glomjai** e-mail [T.Glomjai@sms.ed.ac.uk](mailto:T.Glomjai@sms.ed.ac.uk)

Tel. +4477 8696 5459 in United Kingdom

Tel. +6632 427 049 in Thailand

or Phrachomklao College of Nursing, Petchaburi Province 76000

THAILAND.

If you wish to speak to someone who is not involved in this study about this study, please contact:

***Ms Emily Gribbin** e-mail: [Emily.Gribbin@ed.ac.uk](mailto:Emily.Gribbin@ed.ac.uk)  
Tel. +4413 1650 3889 in United Kingdom  
School of Health in Social Science  
The University of Edinburgh  
Medical School, Doorway 6, Teviot Place  
Edinburgh EH8 9AG*

This proposal has been reviewed and approved by **The Research Ethics Committee of The School of Health in Social Science, The University of Edinburgh** and **The Ethical Review Committee for Research in Human Subjects from Petchaburi Secondary Education Service Area Office 10**, in Thailand, which are committees whose task it is to make sure that research participants are protected from harm.

## **PART II: Certificate of Consent**

**I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily for my child to participate as a participant in this study and understand that I have the right to withdraw her/him from the study at any time without in any way affecting our care at this Centre.**

**Print Name of Participant or Parent or Guardian**

.....

**Signature of Participant or Parent of Guardian**

.....

**Date .....**

### ***If illiterate***

*A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.*

**I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.**

**Print name of witness .....**

**Signature of witness .....**

**Date .....**

**I have accurately read or witnessed the accurate reading of the consent form to the parent/guardian of the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.**

**Print name of researcher.....**

**Signature of researcher .....**

**Date.....**

## Sheet Two: Participants

Nursing Studies  
SCHOOL OF HEALTH IN SOCIAL SCIENCE  
The University of Edinburgh  
Medical School, Teviot Place  
Edinburgh EH8 9AG  
Tel. 0131 650 3889  
Fax 0131 650 3891

### Informed Consent Form

This consent form is for participants in the research titled, "*Alcohol consumption behaviour of young people in Thailand: Perspectives of stakeholders in Petchaburi Province.*"

**Name of Principle Researcher:** Mr. Thanee Glomjai

**Name of Organization:** The University of Edinburgh

**Name of Sponsor:** The Royal Thai Government

**Name of Project:** *Alcohol consumption behaviour of young people in Thailand: Perspectives of stakeholders in Petchaburi Province*

### Part I: Information Sheet

#### Introduction

I am Mr. Thanee Glomjai, a PhD research student of The School of Health in Social Science, University of Edinburgh, United Kingdom. I am doing a research study which might help your teenagers become and stay healthier. In my research I will talk to you and many teenagers, both girls and boys, and ask you/them a number of questions. Whenever researchers study with children, we have to talk to their parents and ask them for their permission. In the same way, if we study with adults we have to ask for their permission too. After you/parents have heard more about the study, you/parents can decide your/their decision. If you/parents agree, then the next thing I will do is to ask you or your daughter/son for their agreement as well. Before you decide, you can talk to anyone you feel comfortable with or you can look for more information before you make decision. Then, both of you have to agree independently, I will begin my study.

In this information sheet, I will give you the information about the research's purpose, participants, protocol, risks and discomforts, benefits, incentives, confidentiality, sharing of research findings, right to refuse or withdraw, and contact person. There may be some words that you do not understand. Please ask me to stop as we go through

the information and I will take time to explain. If you have questions later, you can ask me or another researcher.

### **Purpose**

In this study I will talk to you about what you know about the young people's alcohol consumption behaviours and appropriated prevention strategies. I will invite you to share your knowledge and understanding with us so that we can find ways of meeting young people's needs at the local clinics, community and school.

### **Type of Research Intervention**

A focus group or in-depth interview is used for this study method.

### **Selection of Participants**

I would like to talk to many stakeholders; parents, advisory teachers, a community leader, healthcare providers, a policeman, a Buddhist monk and students about their experiences, knowledge and opinions, and what information or services they want for reduction of alcohol consumption of young people. I would like to ask ask you and many stakeholders to participate because you and they are key persons who are experiencing the problem in this community where the high rate of alcohol consumption of young people definitely showed in the current survey study. The stakeholders in the sample site are the key person to give ideas and provide the appropriate strategies to reduce this problem. Hence, you are the important person that I would like to participate in my study. You can give me ideas, you will find the appropriate ways to control the problem and then you can take part the programme for your community.

### **Voluntary Participation**

You do not have to agree to talk to us. You can choose to say no and any services that you and your family receive at this centre will not change. I know that the decision can be difficult when it involves your children behaviours or your roles. And, it can be especially hard when the research includes sensitive topics like alcohol consumption of young people. You can ask as many questions as you like and I will take the time to answer them. You don't have to decide today. You can think about it and tell me what you decide later.

### **Protocol**

#### **Focus group or in-depth interview:**

You will take part in a discussion with 8-10 other participants or by individual. This discussion will be guided by *Mr. Thanee Glomjai*.

### **Duration**

The interview will take about 1<sup>1/2</sup> to 2 hours of your time and we can do this outside of your work hours.

**Risks and Discomforts**

There is no risk that you share some personal or confidential information. You may feel uncomfortable to talk about some of topics; however, I do not wish this to happen. You may refuse to answer any questions or not take part in a portion of the discussion if you feel the questions are too personal or if talking about them makes you uncomfortable.

**Benefits**

There will be no immediate and direct benefit to you or to your children, but your participation is likely to help us find out more about the health needs of young people and we hope that these will help the stakeholders to meet those needs better in the future. Your information will encourage the best strategies to control alcohol consumption behaviour of young people in your community. Moreover it can generate information and be useful to the other communities.

**Incentives**

You will not be provided with any payment to take part in the research.

**Confidentiality**

I will not be sharing information about you outside of the research team. The information that I collect from this research project will be kept confidential. The information will be put away and no-one but the researchers will be able to see it. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and we will lock that information up with a lock and key.

I will ask you in the group not to talk to people outside the group about what was said in the group. I will, in other words, ask each participant to keep what was said in the group confidential. You should know, however, that we cannot stop or prevent participants who were in the group from sharing things that should be confidential.

**Sharing of Research Findings**

At the end of the study, I will be sharing what we have learnt with the participants and with the community. I will do this by meeting first with the stakeholders and then with the larger community. A written report will also be given to the participants which they can share with their families. I will also publish the results in order that other people may learn from my research.

**Right to refuse or withdraw**

You may choose not to participate in this study and you do not have to take part in this research if you do not wish to do so. Choosing to participate or not will not affect either your own future in any way. You will still have all the benefits that would otherwise be available at the school or community services. You may stop participating in the discussion at any time that you wish without either of you losing any of your rights here.

### **Who to Contact**

If you have any questions you may ask them now or later, even after the study has started. If you wish to ask questions later, you may contact any of the following:

**Mr. Thanee Glomjai** e-mail *T.Glomjai@sms.ed.ac.uk*

*Tel. +4477 8696 5459 in United Kingdom*

*Tel. +6632 427 049 in Thailand*

*or Phrachomklao college of Nursing, Petchaburi Province 76000 THAILAND.*

If you wish to speak to someone who is not involved in this study about this study, please contact:

**Ms Emily Gribbine** e-mail: *Emily.Gribbin@ed.ac.uk*

*Tel. +4413 1650 3889 in United Kingdom*

*School of Health in Social Science*

*The University of Edinburgh*

*Medical School, Doorway6, Teviot Place*

*Edinburgh EH8 9AG*

This proposal has been reviewed and approved by **The Research Ethics Committee of The School of Health in Social Science, The University of Edinburgh** and **The Ethical Review Committee for Research in Human Subjects from Petchaburi Secondary Education Service Area Office 10**, in Thailand, which are committees whose task it is to make sure that research participants are protected from harm.



## **PART II: Certificate of Consent**

**I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to participate as a participant in this study and understand that I have the right to withdraw from the study at any time without in any way affecting my services from this community.**

**Print Name of Participant .....**

**Signature of Participant .....**

**Date .....**

### ***If illiterate***

A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

**I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.**

**Print name of witness.....**

**Signature of witness .....**

**Date .....**

**I have accurately read or witnessed the accurate reading of the consent form to participants/ parents/guardians of the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.**

**Print name of researcher.....**

**Signature of researcher .....**

**Date.....**

## Appendix E: Table of logistic regression analysis

### Logistic regression analysis for selecting a school for Participatory Action Research

Table 1 presents the results when the variable ‘drinking alcohol’ put into the programme. The classification table shows the comparison of the classification rate before and after including predictors of ‘drinking alcohol’ in each school.

**Table 1 The classification table**

Classification Table								
Observed			Predicted					
			Before including predictors			After including predictors		
			Drinking Alcohol		Percentage	Drinking Alcohol		Percentage
			Drink	Not drink	correct	Drink	Not drink	correct
<b>Total</b>	Drinking alcohol	Drink	0	388	.0	250	138	64.4
		Not drink	0	457	100.0	137	320	70.0
	Overall percentage		54.1			67.5		
<b>School A</b>	Drinking alcohol	Drink	0	75	.0	52	23	69.3
		Not drink	0	81	100.0	24	57	70.4
	Overall percentage		51.9			69.9		
<b>School B</b>	Drinking alcohol	Drink	0	51	.0	36	15	70.6
		Not drink	0	84	100.0	15	69	82.1
	Overall percentage		62.2			77.8		
<b>School C</b>	Drinking alcohol	Drink	0	36	.0	28	8	77.8
		Not drink	0	49	100.0	8	41	83.7
	Overall percentage		57.6			81.2		
<b>School D</b>	Drinking alcohol	Drink	41	0	100.0	29	12	70.7
		Not drink	39	0	.0	11	28	71.8
	Overall percentage		51.2			71.3		
<b>School E</b>	Drinking alcohol	Drink	0	39	.0	33	6	84.6
		Not drink	0	40	100.0	12	28	70.0
	Overall percentage		50.6			77.2		

<b>School F</b>	Drinking alcohol	Drink	47	0	100.0	39	8	83.0
		Not drink	32	0	.0	10	22	68.8
	Overall percentage		59.5			77.2		
<b>School G</b>	Drinking alcohol	Drink	0	65	.0	45	20	69.2
		Not drink	0	77	100.0	23	54	70.1
	Overall percentage		54.2			69.7		
<b>School H</b>	Drinking alcohol	Drink	0	34	.0	23	11	67.6
		Not drink	0	55	100.0	8	47	85.5
	Overall percentage		61.8			78.7		

From Table 1, the result shows the overall percentage of prediction without the predictors of each school: 54.1% of the overall by 51.9% of School A, 62.2% of School B, 57.6% of School C, 51.2% of School D, 50.06% of School E, 59.5% of School F, 54.2% of School G, and 61.8% of School H.

After including predictors the percentage of prediction has been changed. This step presents the results when the predictors ‘SEX, YEAR, AGE, GPA, PAY, INCOME, RELATIONSHIP, LIVING and FRIEND’ are included. The classification table shows how the classification error rate has changed from the original 51.9% of School A, 62.2% of School B, 57.6% of School C, 51.2% of School D, 50.6% of School E, 59.5% of School F, 54.2% of School G and 61.8% of School H. By adding the variables I can now predict with 69.9% of School A, 77.8% of School B, 81.2% of School C, 71.3% of School D, 77.2% of School E, 77.2% of School F, 69.7% of School G and 78.7% of School H accuracy.

Rather than using a goodness-of-fit statistic, I want to look at the proportion of cases we have managed to classify correctly. For this I need to look at the classification table, which tells how many of the cases where the observed values of the dependent variable were 1 or 0 respectively have been correctly predicted. In the Classification table, the columns are the two predicted values of the dependent variable, while the rows are the two observed (actual) values of the dependent variable. In a perfect model, all cases will be on the diagonal and the overall percent correct will be 100%. In this study, for example of School A, 69.3% were correctly classified for ‘drink’ group and 70.4% for

‘not drink’ group. Overall 69.9% were correctly classified. This is a considerable improvement on the 51.9% correct classification with the constant model so I know that the model with predictors is a significantly better mode.

**Table 2 Variables in the equation table**

			Variables in the Equation					
			B	S.E.	Wald	df	Sig.	Exp(B)
<b>Total</b>	Step 0	Constant	.164	.069	5.622	1	.018	1.178
<b>School A</b>	Step 0	Constant	.077	.160	.231	1	.631	1.080
<b>School B</b>	Step 0	Constant	.499	.178	7.901	1	.005	1.647
<b>School C</b>	Step 0	Constant	.308	.220	1.973	1	.180	1.361
<b>School D</b>	Step 0	Constant	-.050	.224	.050	1	.823	.951
<b>School E</b>	Step 0	Constant	.025	.225	.013	1	.910	1.026
<b>School F</b>	Step 0	Constant	-.384	.229	2.813	1	.093	.681
<b>School G</b>	Step 0	Constant	.169	.168	1.012	1	.315	1.185
<b>School H</b>	Step 0	Constant	.481	.218	4.861	1	.027	1.618

Table 2 presents the results with only the constant included before any coefficients (i.e. SEX, YEAR, AGE, GPA, PAY, INCOME, RELATIONSHIP, LIVING and FRIEND) are entered into the equation. Logistic regression compares this model with a model including all the predictors (SEX, YEAR, AGE, GPA, PAY, INCOME, RELATIONSHIP, LIVING and FRIEND) to determine whether the latter model is more appropriate. The table suggests that if I knew nothing about our variables and guessed that secondary students would not drink I would be correct 51.9% of School A, 62.2% of School B, 57.6% of School C, 51.2% of School D, 50.6% of School E, 59.5% of School F, 54.2% of School G and 61.8% of School H. When I consider the

statistical significant of the constant it has found that both School B and School H are significant and if included would add to the predictive power of the model.

**Table 3 Omnibus tests of model coefficients**

Omnibus Tests of Model Coefficients					
			Chi-square	df	Sig.
<b>Total</b>	Step 1	Step	112.801	17	.000
		Block	112.801	17	.000
		Model	112.801	17	.000
<b>School A</b>	Step 1	Step	37.675	16	.002
		Block	37.675	16	.002
		Model	37.675	16	.002
<b>School B</b>	Step 1	Step	50.569	16	.000
		Block	50.569	16	.000
		Model	50.569	16	.000
<b>School C</b>	Step 1	Step	41.958	16	.000
		Block	41.958	16	.000
		Model	41.958	16	.000
<b>School D</b>	Step 1	Step	24.146	15	.063
		Block	24.146	15	.063
		Model	24.146	15	.063
<b>School E</b>	Step 1	Step	32.777	16	.008
		Block	32.777	16	.008
		Model	32.777	16	.008
<b>School F</b>	Step 1	Step	38.842	16	.001
		Block	38.842	16	.001
		Model	38.842	16	.001
<b>School G</b>	Step 1	Step	60.272	17	.000
		Block	60.272	17	.000
		Model	60.272	17	.000

School H	Step 1	Step	39.437	16	.001
		Block	39.437	16	.001
		Model	39.437	16	.001

Table 3 presents the results when the predictors ‘SEX, YEAR, AGE, GPA, PAY, INCOME, RELATIONSHIP, LIVING and FRIEND’ are included.

**Model chi-square.** This step presents the overall significance is tested. There are two hypotheses to test in relation to the overall fit of the model:

H<sub>0</sub> The model is a good fitting model.

H<sub>1</sub> The model is not a good fitting model (i.e. the predictors have a significant effect).

In this research *model chi-square* has different degrees of freedom of each school, the value of 37.675 and a probability of  $p < .002$  of School A, 50.569 and  $p < .000$  of School B, 41.958 and  $p < .000$  of School C, 24.146 and  $p < .063$  of School D, 32.777 and  $p < .008$  of School E, 38.842 and  $p < .001$  of School F, 60.272 and  $p < .000$  of School G and 39.437 and  $p < .001$  of School H (Table 3). Thus, the indication is that the model has a poor fit, with the model containing only the constant indicating that the predictors do have a significant effect and create essentially a different model. So we need to look at the predictors to determine if one or all of them are significant predictors.

**Table 4 Model Summary**

Model Summary				
	Step	- 2 Log likelihood	Cox & Snell R square	Nagelkerke R square
Total	1	1052.978	.125	.167
School A	1	178.356	.215	.286
School B	1	128.431	.312	.425

School C	1	73.881	.390	.524
School D	1	86.708	.261	.347
School E	1	76.728	.340	.453
School F	1	67.810	.388	.524
School G	1	135.566	.346	.462
School H	1	78.941	.358	.487

**Model Summary.** This step presents the coefficient of determination  $R^2$ . *Cox and Snell's R-Square* attempts to imitate multiple R-Square based on 'likelihood', but its maximum is usually less than 1.0 (Burns and Burns, 2008). Here it is indicating that 21.5% of the variation in the dependent variable is explained by the logistic model for School A, 31.2% of School B, 39.0% of School C, 26.1% of School D, 34.0% of School E, 38.8% of School F, 34.6% of School G and 35.8% of School H. The *Nagelkerke* modification that does range from 0 to 1 is a more reliable measure of the relationship. *Nagelkerke's  $R^2$*  will normally be higher than the *Cox and Snell* measure. *Nagelkerke's  $R^2$*  is the most-reported of the R-squared estimates. In this study it is 0.286, indicating a moderately strong relationship of 28.6% between the predictors and the prediction for School A, 42.5% of School B, 52.4% of School C, 34.7% of School D, 45.3% of School E, 52.4% of School F, 46.2% of School G and 48.7% of School H.

**Table 5 Hosmer and Lemeshow Test**

Hosmer and Lemeshow Test				
	Step	Chi-square	df	Sig.
Total	1	12.961	8	.113
School A	1	8.850	8	.355
School B	1	12.576	8	.127
School C	1	8.734	7	.272
School D	1	8.958	8	.346
School E	1	3.272	8	.916
School F	1	3.334	8	.912
School G	1	10.613	8	.225
School H	1	4.143	8	.844

**Hosmer and Lemeshow Statistic.** An alternative to *model chi-square* is the *Hosmer and Lemeshow* test which divides subjects into 10 ordered groups of subjects and then compares the number actually in the each group (observed) to the number predicted by the logistic regression model (predicted). The 10 ordered groups are created based on their estimated probability; those with estimated probability below .1 form one group, up to with probability .9 to 1.0. Each of these categories is further divided into two groups based on the actual observed outcome variable (success, failure). The expected frequencies for each of the cells are obtained from the model. A probability (p-value) is computed from the chi-square distribution with 8 degrees of freedom to test the fit of the logistic model. If the *H-L goodness-of-fit* test statistic is greater than .05, as I want for well-fitting models, we fail to reject the null hypothesis that there is no difference between observed and model-predicted values, implying that the model's estimates fit the data at an acceptable level. That is, well-fitting models show non-significance on the *H-L goodness-of-fit* test. This desirable outcome of non-significance indicates that the model prediction does not significantly differ from the observed.

The H-L statistic assumes sampling adequacy, with a rule of thumb being enough cases so that 95% of cells (typically, 10 docile groups times 2 outcome categories = 20 cells) have an expected frequency > 5. In this case the H-L statistic of each school has a



significance  $p > .05$  which means that it is not statistically significant and therefore the model is quite a good fit.

When I compare the H-L statistic of each school I found that the H-L statistic of School E has a significance  $p = .916$  (Table 5) which is the greatest not statistically significant. This means the model of School E is the best fit follows School F and School H.

**Table 6 Variables in the equation**

School	Variable	Odds Ratio	Sig.	95% confidence interval	
				Lower	Upper
School A	SEX(1)(Girls)	.756	.465	.358	1.600
	YEAR Matthayomsuksa 4		.007		
	YEAR(1)Matthayomsuksa 5	6.831	.006	1.757	26.557
	YEAR(2)Matthayomsuksa 6	5.754	.002	1.853	17.868
	AGE	1.667	.084	.934	2.973
	GPA	1.998	.096	.885	4.509
	Students' monthly expenditure	1.000	.234	.999	1.000
	Family income	1.000	.489	1.000	1.000
	Relationship(Good)		.636		
	Relationship(1)(Fair)	.734	.820	.051	10.637
	Relationship(2)(Poor)	1.296	.863	.068	24.652
	Living (Living with parents/guardians)		.905		
	Living(1)(Living with cousin's house)	4.780	.999	.000	
	Living(2)(Living with someone)	6.372	.999	.000	
	Friend (All or almost all)		.030		
	Friend(1)(More than half)	.261	.011	.093	.736
	Friend(2)(Half)	.291	.032	.094	.897
	Friend(3)(Less than half)	.199	.033	.045	.878
	Friend(4)(Almost none)	.895	.866	.246	3.256
	Friend(5)(None)	1.222	.793	.275	5.431
	Constant	.000	.999		

School	Variable	Odds Ratio	Sig.	95% confidence interval	
				Lower	Upper
<b>School B</b>	SEX(1)	.147	.000	.057	.379
	Year		.175		
	Year(1)	4.692	.088	.795	27.712
	Year(2)	3.390	.079	.869	13.233
	AGE	.965	.931	.427	2.178
	GPA	1.196	.715	.459	3.118
	PAY	.999	.171	.999	1.000
	Income	1.000	.860	1.000	1.000
	Relationship		.138		
	Relationship(1)	27.954	.049	1.020	766.294
	Relationship(2)	33.417	.056	.915	1220.434
	Living		.245		
	Living(1)	.000	1.000	.000	.000
	Living(2)	.000	1.000	.000	.000
	Friend		.038		
	Friend(1)	.144	.008	.035	.598
	Friend(2)	.123	.008	.026	.574
	Friend(3)	.087	.006	.015	.502
	Friend(4)	.099	.009	.018	.556
	Friend(5)	1.781	.715	.080	39.503
	Constant	1.701	1.000		
<b>School C</b>	SEX(1)	.424	.213	.110	1.638
	Year		.049		
	Year(1)	4.389	.162	.552	34.911
	Year(2)	9.269	.014	1.572	54.665
	AGE	1.880	.157	.785	4.504
	GPA	2.417	.210	.608	9.604
	PAY	1.000	.826	.999	1.001
	Income	1.000	.146	1.000	1.000

School	Variable	Odds Ratio	Sig.	95% confidence interval	
				Lower	Upper
	Relationship		.603		
	Relationship(1)	3.257	.489	.115	92.537
	Relationship(2)	6.088	.335	.155	239.607
	Living		1.000		
	Living(1)	.000	1.000	.000	.000
	Living(2)	92.974	1.000	92.974	.000
	Friend		.023		
	Friend(1)	.085	.008	.014	.530
	Friend(2)	.148	.057	.021	1.061
	Friend(3)	.041	.014	.003	.531
	Friend(4)	1.206	.873	.121	12.009
	Friend(5)	.414	.498	.032	5.313
	Constant	11.488	1.000		
<b>School D</b>	SEX(1)	4.481	.017	1.314	15.278
	Year		.848		
	Year(1)	1.290	.739	.304	5.470
	Year(2)	1.580	.572	.323	7.724
	AGE	.990	.973	.557	1.761
	GPA	1.488	.480	.494	4.484
	PAY	1.000	.131	.999	1.000
	Income	1.000	.255	1.000	1.000
	Relationship		.513		
	Relationship(1)	1.250	.883	.064	24.268
	Relationship(2)	3.065	.469	.148	63.390
	Living(1)	4.642	.328	.214	100.840
	Friend		.016		
	Friend(1)	.071	.001	.014	.359
	Friend(2)	.311	.184	.055	1.742
	Friend(3)	.131	.089	.013	1.359
	Friend(4)	1.953	.533	.238	16.062

School	Variable	Odds Ratio	Sig.	95% confidence interval	
				Lower	Upper
	Friend(5)	.192	.109	.025	1.448
	Constant	.140	.710		
<b>School E</b>	SEX(1)	2.575	.134	.747	8.875
	Year		.107		
	Year(1)	2.339	.385	.344	15.915
	Year(2)	5.119	.036	1.093	23.965
	AGE	2.002	.082	.915	4.378
	GPA	1.922	.190	.723	5.109
	PAY	1.000	.151	.999	1.000
	Income	1.000	.323	1.000	1.000
	Relationship		.753		
	Relationship(1)	.814	.904	.029	22.899
	Relationship(2)	1.631	.794	.041	64.463
	Living		1.000		
	Living(1)	9.589	.999	.000	
	Living(2)	3.654	.999	.000	
	Friend		.132		
	Friend(1)	.095	.012	.015	.591
	Friend(2)	.117	.030	.017	.817
	Friend(3)	.463	.547	.038	5.668
	Friend(4)	.797	.887	.035	18.037
	Friend(5)	.150	.166	.010	2.193
	Constant	.000	.999		
<b>School F</b>	SEX(1)	6.538	.049	1.006	42.508
	Year		.009		
	Year(1)	8.207	.056	.948	71.093
	Year(2)	.289	.184	.046	1.803
	AGE	1.078	.876	.418	2.785

School	Variable	Odds Ratio	Sig.	95% confidence interval	
				Lower	Upper
	GPA	6.240	.037	1.114	34.961
	PAY	1.000	.299	1.000	1.000
	Income	1.000	.455	1.000	1.000
	Relationship		.915		
	Relationship(1)	1.556	1.000	.000	
	Relationship(2)	98916606.3	1.000	.000	
	Living		.129		
	Living(1)	15.743	1.000	.000	
	Living(2)	319.236	1.000	.000	
	Friend		.039		
	Friend(1)	.028	.010	.002	.432
	Friend(2)	.104	.070	.009	1.208
	Friend(3)	1.113	.942	.062	19.848
	Friend(4)	.017	.011	.001	.396
	Friend(5)	.019	.096	.000	2.023
	Constant	.000	.999		
<b>School G</b>	SEX(1)	.282	.011	.106	.752
	Year		.003		
	Year(1)	12.924	.001	2.698	61.907
	Year(2)	1.533	.484	.463	5.073
	AGE	1.334	.363	.717	2.481
	GPA	1.049	.933	.344	3.200
	PAY	1.000	.317	.999	1.000
	Income	1.000	.874	1.000	1.000
	Relationship		1.000		
	Relationship(1)	.000	.999	.000	
	Relationship(2)	.000	.999	.000	
	Living		.836		
	Living(1)	.000	1.000	.000	
	Living(2)	.000	1.000	.000	

School	Variable	Odds Ratio	Sig.	95% confidence interval	
				Lower	Upper
	Living(3)	.000	1.000	.000	
	Friend		.004		
	Friend(1)	.120	.001	.035	.410
	Friend(2)	.152	.004	.042	.549
	Friend(3)	.563	.610	.062	5.114
	Friend(4)	.284	.109	.061	1.321
	Friend(5)	.978	.975	.235	4.068
	Constant	4.956	.999		
<b>School H</b>	SEX(1)	.442	.214	.122	1.601
	Year		.001		
	Year(1)	.033	.000	.005	.202
	Year(2)	.275	.083	.064	1.182
	AGE	.754	.414	.382	1.485
	GPA	1.958	.248	.626	6.129
	PAY	1.001	.141	1.000	1.002
	Income	1.000	.463	1.000	1.000
	Relationship		1.000		
	Relationship(1)	.000	.999	.000	
	Relationship(2)	.000	.999	.000	
	Living		.897		
	Living(1)	.433	.663	.010	18.524
	Living(2)	.392	.643	.007	20.534
	Friend		.235		
	Friend(1)	.111	.032	.015	.832
	Friend(2)	.208	.177	.021	2.032
	Friend(3)	.032	.020	.002	.578
	Friend(4)	.126	.100	.011	1.483
	Friend(5)	.177	.211	.012	2.666
	Constant	3.973	.999		

***Variables in the Equation.*** The Variables in the Equation table (Table 6) has several important elements. The *Wald statistic* and associated probabilities provide an index of the significance of each predictor in the equation. The *Wald statistic* has a chi-square distribution.

The *Wald* is to take the significance values and if less than .05 reject the null hypothesis as the variable does make a significant contribution. In this case, for example of School A, I note that YEAR(1), YEAR(2), FRIEND(1), FRIEND(2) and FRIEND(3) contributed significantly to the prediction ( $p=.006$ ,  $.002$ ,  $.011$ ,  $.032$  and  $.033$  respectively) but the others did not ( $p>.05$ ). I may well want to drop independents from the model when their effect is not significant by the *Wald statistic*.

The *Exp(B) column* in Table 6 presents the extent to which raising the corresponding measure by one unit influences the odds ratio. I can interpret *Exp(B)* in terms of the change in odds. If the value exceeds 1 then the odds of an outcome occurring increase; if the figure is less than 1, any increase in the predictor leads to a drop in the odds of the outcome occurring. For example of School A, the *Exp(B)* value associated with YEAR(1) is 6.831. Hence when YEAR(1) is raised by one unit the odds ratio is around 6.8 times as large and therefore students are 6.8 more times likely to belong to ‘drink’ group. The ‘*B*’ values are the logistic coefficients that can be used to create a predictive equation.

## Appendix F: The focus group and in-depth interview guide

**Research title:** *Alcohol consumption behaviour of young people in Thailand: Perspectives of stakeholders in Petchaburi Province*

**Name of Principle Researcher:** Mr Thanee Glomjai

**Group I: Advisory teacher, School principal, Community leader, Police, Healthcare providers, and Buddhist monks**

Good morning and welcome. Thank you for coming to talk with me today. We will be here for about 1<sup>1/2</sup> to 2 hours to discuss alcohol consumption in young people. I would like to ask you questions in relation to your perceptions about alcohol consumption in young people and the acceptability of prevention strategies for young people in Petchaburi Province, Thailand. I also want to hear your opinion, and your opinion on these subjects is important. So please share whatever is in your mind. There are no right or wrong answers. Your thoughts will be valued. However, you can decide not to discuss and skip any questions that make you feel uncomfortable and we can end the focus group at any time.

There are no right or wrong answers to the questions I am about to ask. Please feel free to share your point of view even if it differs from what others have said. If you want to follow up on something that someone has said, if you want to agree, disagree, or give an example, feel free to do that. Don't feel as if you have to respond to me all the time. Feel free to have a conversation with the other participants about the questions. I am here to ask questions, listen, and make sure that everyone has a chance to share. I am interested in hearing from each of you. So if you are talking a lot, I may ask you to give others a chance. And if you are not saying much, I may call on you. I just want to make sure that we hear from all of you. Feel free to get up or get more refreshments if you would like.

I and my assistant will be taking notes to help us to remember what is said. We are also tape recording the session because we don't want to miss any of your comments.

Actually, I want to inform you that your identity will be protected as a participant in this focus group. You will not be identified in any report or publication of this study or its results. Your name will not appear on any transcripts. However, I want to ask for your collaboration to keep everything we discuss today confidential and not share this information with anyone outside the group.

**Opening questions** (are used to get people talking and feeling comfortable. They should be easy to answer, but should not emphasize differences among group members.)



1. Please tell us your name and a bit more about your background.

**Introductory questions** (are used to get the group to start thinking about the topic at hand. They help to focus the conversation.)

1. What is your opinion of today young people's alcohol consumption behaviour?
2. Could you explain a bit more about your opinion of today's young people's health and results from alcohol drinking?

**Transition questions** (which provide a link between the introductory questions and the key questions. They typically ask participants to go into more depth than introductory questions.)

1. What does a strategy to control alcohol consumption in young people mean to you?
2. How might providing a strategy to control alcohol consumption in young people be important?

**Key questions** (focus on the major areas of concern. The majority of the time is devoted to discussions of these questions.)

1. What are appropriate strategies for controlling alcohol consumption in young people?
2. What is your opinion of Alcohol Education Lessons as a part of a broad health education curriculum?
3. How does the Alcohol Act/policy in Thailand affect young people?
4. How can your community promote appropriate strategies to control alcohol consumption in young people?

**Prompt:** What resources are available in your community to support these?

5. How could providing the Buddhist way for young people be important?

**Prompt I:** How can the Buddhist way control alcohol consumption in young people?

**Prompt II:** Could you tell us how can you promote the Buddhist way in strategies to control alcohol consumption in young people?

**Prompt III:** What resources are available to support these?

**Ending questions** (bring the session to closure.)

1. Have I managed to adequately summarise the discussions?
2. Is there anything we should have talked about, but didn't?

## **Group II: Parents**

Good morning and welcome. Thank you for agreeing to talk with me today. We will be here for about 1<sup>1/2</sup> to 2 hours to discuss alcohol consumption in young people. I would like to ask you questions in relation to your perception about young people's

alcohol consumption and the acceptability of prevention strategies for young people in Petchaburi Province, Thailand. I also want to hear your opinion, and your opinion on these subjects is important. So please share whatever is in your mind. There are no right or wrong answers. Your thoughts will be valued. However, some of the questions may make you embarrassed or uncomfortable so please remember that you can ask me to skip any questions that make you feel uncomfortable and we can end the interview at any time.

There are no right or wrong answers to the questions I am about to ask. I expect that you have differing points of views. Please feel free to share your point of view even if it differs from what others have said. If you want to follow up on something that someone has said, if you want to agree, disagree, or give an example, feel free to do that. Don't feel as if you have to respond to me all the time. Feel free to have a conversation with the other participants about the questions. I am here to ask questions, listen, and make sure that everyone has a chance to share. We are interested in hearing from each of you. So if you are talking a lot, I may ask you to give others a chance. And if you are not saying much, I may call on you. I just want to make sure that we hear from all of you. Feel free to get up or get more refreshments if you would like.

I and my assistant will be taking notes to help us to remember what is said. We are also tape recording the session because we don't want to miss any of your comments.

Also, your identity will be protected as a participant in this study. You will not be identified in any report or publication of this study or its results. Your name will not appear on any transcripts. However, I want to ask for your collaboration to keep everything we discuss today confidential and not share this information with anyone outside the group.

### **Opening questions**

1. Please tell us your name and a bit more about your background.

### **Introductory questions**

1. What is your opinion of today's young people's alcohol consumption behaviour?
2. Could you explain a bit more about your opinion of today's young people's health and results from alcohol drinking?

### **Transition questions**

1. What does a strategy to control alcohol consumption in young people mean to you?
2. How could providing a strategy to control alcohol consumption in young people be important?

3. What Alcohol Education have you taught to your sons/daughters?

**Prompt:** Please explain how you have taught alcohol education at home for your sons/daughters.

### **Key questions**

1. What are appropriate strategies for controlling alcohol consumption in young people?
2. How can you promote appropriate strategies to control alcohol consumption in young people?

**Prompt:** What resources are available in your home to support these?

3. What are the barriers to supporting appropriate strategies to control alcohol consumption in young people at your home?
4. How could providing the Buddhist way for young people be important?

**Prompt I:** How can the Buddhist way control alcohol consumption in young people?

**Prompt II:** Could you tell us how can you promote Buddhist way strategies to control alcohol consumption in young people?

**Prompt III:** What resources are available to support these?

### **Ending questions**

1. Have I managed to adequately summarise the discussions?
2. Is there anything we have missed?

### **Group III: High School Students**

Good morning and welcome. Thank you for coming to talk with me today. We will be here about 1<sup>1/2</sup> to 2 hours to discuss alcohol consumption in young people that you have experienced from home, school and communities. I also want to hear your opinion about your perceptions, expectation of alcohol consumption characteristics and appropriate prevention strategies. Your opinion on these subjects is very important so please share whatever is in your mind. There are no right or wrong answers. Your thoughts will be valued. However, some of the questions may make you embarrassed or uncomfortable so please remember that you can decide not to discuss questions that make you feel uncomfortable and we can end the focus group at any time.

There are no right or wrong answers to the questions I am about to ask. I expect that you have differing points of views. Please feel free to share your point of view even if it differs from what others have said. If you want to follow up on something that someone has said, if you want to agree, disagree, or give an example, feel free to do that. Don't feel as if you have to respond to me all the time. Feel free to have a conversation with the other participants about the questions. I am here to ask questions, listen, and make sure that everyone has a chance to share. I am interested in hearing

from each of you. So if you are talking a lot, I may ask you to give others a chance. And if you are not saying much, I may call on you. I just want to make sure that we hear from all of you. Feel free to get up or get more refreshments if you would like.

I and my assistant will be taking notes to help us remember what is said. We are also tape recording the session because we don't want to miss any of your comments.

Again, I want to inform that your identity will be protected as a participant in this focus group. You will not be identified in any report or publication of this study or its results. Your name will not appear on any transcripts. However, I want to ask for your collaboration to keep everything we discuss today confidential and not share this information with anyone outside the group.

### **Opening questions**

1. Please tell us your name and a bit more about your background.

### **Introductory questions**

1. Could you tell us about your opinion of today young people's alcohol consumption behaviour?
2. What are adults' opinions of Thai adolescents' alcohol consumption behaviour?

### **Transition questions**

1. Could you tell us about what Alcohol Education content you have received from your parents, teachers, communities or healthcare providers?  
**Prompt I:** How could Alcohol Education be important for young people at your age?  
**Prompt II:** What else do you want to know more about Alcohol Education from them?
2. Could you tell us about your opinion to reduce alcohol consumption in young people? **Prompt:** Could you give us an example?

### **Key questions**

1. What are appropriate strategies for controlling alcohol consumption in young people?
2. Who are appropriate persons to take part in appropriate strategies to control alcohol consumption in young people?  
**Prompt:** Why do you think these persons are appropriate?
3. How does the Alcohol Act/policy in Thailand affect young people?
4. How could providing the Buddhist way for young people be important?

**Prompt I:** How can the Buddhist way control alcohol consumption in young people?

**Prompt II:** Could you tell us how can you promote Buddhist way strategies to control alcohol consumption in young people?

**Prompt III:** What resources are available to support these?

**Ending questions**

1. Have I managed to adequately summarise the discussions?
2. What else do you want to share about alcohol consumption in young people?  
finish